S. HRG. 99-683

REAUTHORIZATION OF THE HEAD START PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

ON

EXAMINING PROPOSED LEGISLATION AUTHORIZING FUNDS FOR THE HEAD START PROGRAM

FEBRUARY 27, 1986

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REAUTHORIZATION OF THE HEAD START PROGRAM

THURSDAY, FEBRUARY 27, 1986

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS, AND ALCOHOLISM,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room SD-430, Dirksen Senate Office Building, Senator Paula Hawkins (chairman of the subcommittee) presiding.

Present: Senators Hawkins, Grassley, Kerry, Quayle, and Dodd.

OPENING STATEMENT OF SENATOR HAWKINS

Senator HAWKINS. Good morning.

Today we are considering the reauthorization of the Head Start Program.

Alexander Pope in his "Moral Essays" in the 1700's wrote that, "As the twig is bent, the tree is inclined." To paraphrase on his immortal words, I suggest that as the childhood is spent, so the adult is defined.

The Head Start Program was designed to have a positive impact on the child's preschool environment. It recognizes the importance of the family and the first 5 years of life in determining the child's self-concept, social competences, and intellectual readiness in making a healthy start toward self-sufficiency, independence, and success as an adult.

President Reagan has stressed that programs for the poor and the unemployed must become self-sufficiency programs instead of dependency programs; programs to help people help themselves, instead of entitlement programs.

Today we begin the first of a series of reauthorization of programs designed to eradicate the root causes of poverty. As we examine these programs, we will be asking whether they are mere Band-Aids to the wounds of poverty or whether they serve as corrective therapy, changing the face of poverty.

Do they create the expectation of a free lunch throughout one's life, or do they serve as helping hands, reaching across a chasm, forming a bridge for those who seek the American dream of opportunity based on work, family values, and equality before the law?

The first program to be scrutinized is Head Start. Head Start was launched 20 years ago in the summer of 1965 as a program to

provide 3- to 5-year-old children in poor families with an opportunity to break out of the cycle of poverty.

Today it is hard to imagine the public opposition and fear that this program initially generated. After two decades, Head Start serves more than 400,000 children each year. Yet, this is less than one-fifth of the children who qualify for the program.

Head Start is not a stopgap program. It is mandated to address the whole development of the child: the health, social, psychological, intellectual, and familial needs. It recognizes parents as the primary educators of the child and includes them in the classroom, in the policy decisions of the local program, and in parent education programs. In this way, Head Start strengthens the family.

Let me give you an example of how Head Start works with parents. In Alban, AL, parents start in a discussion group that teaches them about normal child development—nonabusive methods of discipline, balanced diets, and the emotional needs of their children. They begin to develop professional skills and can qualify to work as teachers' aides. In fact, I have met many mothers who work as teachers' aides when I visit the Head Start Program.

The second part of the program uses computers donated by the children's defense fund. Both parents and children use these computers. And I might say, that the children are less afraid of the computers than their parents. The parents learn to write résumés, to type, and to do word processing and computer programming. As they gain confidence, they are encouraged to find a job in the private sector and then to return to Head Start to help recruit and train more parents.

The success stories of Head Start are legion. Jaime Davila, one of the first Head Start children, came from a family that immigrated to the United States from Mexico. Neither parent had a high school education. Today, Jaime is a Harvard graduate about to complete law school. He has a job at a prestigious Houston law firm waiting for him.

Cyrana Longest was a Head Start child in 1965 in Holly Springs, MS. A winner of the Miss Black Mississippi title, she is today continuing her involvement in the black community by serving on the National Negro College Advisory Board. Cyrana is a legislative aide to Senator Thad Cochran. One of her areas of legislative responsibility is Head Start. She says she has accomplished a great deal because of the ongoing relationships she formed with her Head Start teachers and other members of her community involved in the program

Voneeva Pettigrew was a parent in Head Start. When her second son started the program, she became the parent coordinator. She says that she learned all of her organizing skills there. Mrs. Pettigrew is the founder of Parents and Youths Against Drug and Alcohol Abuse. She also founded the first national ethnic family group working to eradicate drug and alcohol abuse among the youth of this country.

The Lee County Head Start in Fort Myers, FL, wrote to me about Leion Knight, a freshman at Florida State University, who had a choice between joining a professional baseball team or going to college. He chose college and is now well on his way to making a name for himself in national collegiate football.

The drawings that we have placed up here on the podium and those in the hall were sent to me from Florida Head Start programs. Dorcas Hardy and I visited several of these centers. These drawings bring fond memories of the things the children are learning—food groups, dental hygiene, story hours, and playing together.

Children are our most precious natural resource. We must do all we can to assure that they have the opportunity to reach their fullest potential in this wonderful country.

At this point the opening statements of Senators Grassley, Kerry, Dodd, and Quayle will be inserted in the record.

[The statements referred to above follows:]

OPENING STATEMENT OF SENATOR CHARLES E. GRASSLEY

Senator GRASSLEY. Thank you Senator Hawkins for holding this hearing today on the reauthorization of Head Start.

I am here today as a fan of the Head Start Program which has had remarkable success as a tool for social and educational development of low-income preschoolers.

At the core of this program's success is the high level of involvement by parents: For every 15 children in the program, 10 parents volunteer services to their local projects. Strong public support in Iowa in 1984-85 resulted in 220,000 hours of volunteer services to the program, which in dollar terms would be at minimum, the equivalent of $737,000 at the minimum wage rate of $3.15 an hour.

Head Start also enriches youngsters by drawing from each community's senior centers, high schools, colleges, and businesses. This meshing of family life with diverse educational, social, health, and business resources has vastly multiplied the investment of tax dollars in this program.

In the long run, this society, and taxpayers, would pay far more in both human and economic resources, if we abandon this successful program. By nurturing the mental and social development of almost half a million low-income children, we will nudge many out of poverty, into productive, stable—and, yes, taxpaying lives.

What a reasonable investment, considering the enormous dividends.

I welcome all the witnesses here today and look forward to your testimony.

OPENING STATEMENT OF SENATOR JOHN F. KERRY

Senator KERRY. I want to thank you, Madam Chairwoman, for holding this hearing on the reauthorization of the Head Start Program. I know that you share my hope that Congress move quickly to reauthorize this important program which has proven since it was enacted more than 20 years ago, to be a model for how Government can play a role that enhances our ability to provide greater opportunities for many of our citizens.

The first graduates of the initial Head Start Program are just now coming of age and they are helping to prove to the doubters that with a little concentrated focus and attention, we can provide some of the basic skills that are necessary to share in the health and prosperity that characterizes the American dream.

Our witnesses know that the program is far from perfect. The nearly one-half million children that Head Start served in last fiscal year is estimated to be only 18 percent of those children eligible. There are also clearly administrative problems that any entity is going to have when the teacher salary has been kept for the last several years at just under $8,683 a year. Clearly, we should take this opportunity to study the problems that you as administrators, providers, and even graduates, face with this program.

All of us in Congress understand the need for deficit reduction. However, through the years, Congress has resisted temptations to cut back on this program because our predecessors recognized its efficiency and effectiveness. I am hopeful that we will shortly reaffirm our commitment to those in need who want to transcend their cycle of poverty. The way to do that is to reauthorize this program and to appropriate the funds needed to better fulfill its mandate.

OPENING STATEMENT OF SENATOR CHRISTOPHER J. DODD

Senator DODD. Madam Chairwoman, the hearing this morning highlights one of the greatest success stories ever: Namely, project Head Start. As the New York Times noted in an editorial: ". . . American society does know one sure way to lead poor children out of a life of poverty . . .—Project Head Start."

Given the crisis of children in poverty in this country, Head Start is good news indeed. For the biggest risk to the health, safety, and future well-being of close to 14 million American children is poverty. One out of every four children under the age of 6 now lives in a family whose income falls below the poverty line. For minority preschoolers, that figure is even higher: Every other black child and close to every other Hispanic child will celebrate their sixth birthdays in poverty.

Yet poverty does not afflict only our very youngest citizens. Children of all ages now constitute the poorest age group in America. More than 1 out of 5 Americans under the age of 18 is poor. In the cities of Hartford and New Haven in my State of Connecticut, that figure is higher with every other child living in poverty. And in cities across the country, adults living in families with children are now three times more likely to be poor than other adults.

Over the past 6 years, childhood poverty rates have skyrocketed. Even by conservative estimates, close to 4 million children have been added to the poverty rolls—the sharpest increase on record. Moreover, the depth of childhood poverty has intensified. Over 40 percent of all poor children live in families whose incomes do not even reach the halfway mark with respect to the poverty level.

The risks posed by childhood poverty are numerous and serious. Poverty results in a greater chance of abuse and neglect, poor health, and even death. Poor children who survive face a greater risk of dropping out of school, becoming teen parents, and ending up unemployed. The birth rate among white, unmarried adolescents has increased in recent years. And, as the children's defense fund pointed out in a study entitled, "Black Children, White Children," black children today are more likely to be born into poverty, lack early prenatal care, have an adolescent or single mother, have

an unemployed parent, be unemployed themselves as teenagers, and not go to college upon high school graduation.

But with the Head Start Program, we have a well-proven way to help children escape from poverty. The high/scope educational research foundation conducted a landmark study of high quality preschool programs like Head Start. This study, entitled "Changed Lives," followed a group of poor children from age 3 to adulthood. Half had attended a high quality preschool. The other half had not. Those with the preschool experience were twice as likely to graduate from high school, go on to college or vocational training, and to get jobs. Those without the preschool experience were more likely to drop out of school, to become teen parents, and to end up unemployed and dependent upon the welfare system. As cochairmen, of the Senate children's caucus, Senator Specter and I will be distributing copies of "Changed Lives" to all our colleagues in the Senate.

The costs of high quality preschool education are not insignificant. But the costs of failing to provide children at risk with such a headstart on life are much, much higher. The Center for Population Options just released a study revealing that teenage pregnancies in this country cost the welfare system $16 billion last year. And the cost of unemployment and Welfare dependency in human terms show up in the grim statistics of child abuse and family violence.

As we consider the reauthorization of head start, we must keep in mind that at present, we only reach 18 percent of all children who are eligible for such services. And even though Head Start is not targeted to be cut in the President's fiscal year 1987 budget, reductions in other essential programs such as the community services block grant and the Child-Care Food Program will diminish the quality of Head Start. Thus, I am a cosponsor of S. 2081, to reauthorize Head Start in tandem with other critically important human services programs.

In closing, I look forward to hearing the testimony of our distinguished witnesses this morning. I am especially proud of two Head Start parents who have traveled from Norwalk in my State of Connecticut. They exemplify the difference which Head Start can make in improving the lives of children and parents. They are examples of the very best that Connecticut has to offer just as Head Start is an example of the very best that our country has to offer.

OPENING STATEMENT OF SENATOR DAN QUAYLE

Senator QUAYLE. Madam Chairwoman, I want to commend you for holding this hearing on the reauthorization of one of our Nation's most important and successful education programs, the Head Start Act.

This act has had tremendous significance for many disadvantaged children and their families, and has resulted in a marked improvement in educational performance for thousands of children who might otherwise have become lost in the system.

The Head Start Program is designed to promote the educational and social competence of preschool children and their families. "Changed Lives," often referred to as the High Scope report, which

is a longitudinal study of children who participated in Head Start Programs, stated:

> The basic finding is that early childhood education of high quality can improve the lives of low-income children and their families; most important from the public viewpoint, it has payoffs for society as well in that it can enhance the quality of life for the community as a whole.

The High Scope study showed that children who attended preschool, almost identical to Head Start, had better grades, fewer failing marks, and fewer absences in elementary school than their nonpreschool peers; required fewer special education services and were more likely to graduate from high school, with a graduation rate of 67 percent for preschoolers versus a graduation rate of only 49 percent for nonpreschoolers. The preschool students were also more likely to continue their education or to get vocational training, with 38 percent of the preschoolers continuing their education versus 21 percent of nonpreschoolers.

The study also showed that preschool led to higher levels of employment and higher earnings by the age of 19 for study subjects. The researchers agreed that preschool education increased a subject's economic independence, reduced dependence upon welfare, and offered an opportunity for long-term socioeconomic improvement, meaning, in simple terms, that preschool and Head Start can help to break the cycle of poverty.

In one other important area, the study showed that students who attended preschool had both a lower rate of pregnancy in their teen years and a lower reliance on welfare assistance. Clearly, Head Start has many more benefits to individuals and to society than just teaching young children the alphabet and number system. This study shows the dramatic impact and success that Head Start or quality preschool has upon a participant's life.

One of the important components of the Head Start Program is the involvement of parents. In the Head Start Program operated in Indianapolis, which serves approximately 1,000 children from Marion County, parents are seen as a key ingredient to the success of the program. The Indianapolis Head Start Program provides valuable assistance to families, such as improving the family's attitude toward health care, especially if the child has a physical or mental disability, enhancing the family's diet and nutrition, increasing the ability of the family and the child to relate to each other, increasing parents' knowledge of child development, involving parents in reading and learning experiences, and teaching them how to provide a conducive environmnent for learning at home, as well as offering information on available health, mental health, dental, and nutrition community services.

Additionally, the Head Start Program in Indianapolis takes advantage of the volunteers under the Foster Grandparents Program, an excellent use of the time and energy of those volunteers that integrates community service activities for the benefit of all. Much of the success of Head Start is due to the flexibility that it grants States and localities to design the most effective approaches to their community needs, and this degree of local control has ensured responsive projects.

I strongly support the reauthorization of the Head Start Act, and I am also pleased that the administration in its 1987 fiscal year

budget request has recognized the importance of the program and recommended level funding for Head Start.

I look forward to working with the chairwoman of this subcommittee on the reauthorization of the Head Start Program. Again, I want to indicate my full and strong support for this very successful program, which has helped many thousands of young children in Indiana and throughout the country.

Senator HAWKINS. Our first witness today, on the development of the Head Start Program is Dorcas Hardy, Assistant Secretary for Human Development Services, U.S. Department of Health and Human Servcies.

Welcome, Dorcas. We look forward to your statement.

STATEMENT OF DORCAS R. HARDY, ASSISTANT SECRETARY FOR HUMAN DEVELOPMENT SERVICES, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY DODIE LIVINGSTON, COMMISSIONER, ADMINISTRATION FOR CHILDREN, YOUTH, AND FAMILIES, AND CLENNIE MURPHY, ACTING ASSOCIATE COMMISSIONER, HEAD START BUREAU

Ms. HARDY. Thank you, Senator.

I am accompanied here today by Dodie Livingston, Commissioner, Administration for Children, Youth, and Families, and Clennie Murphy, the Acting Associate Commissioner of the Head Start Bureau. We have submitted a rather lengthy statement for the record, but I would like to highlight some of that at this time.

As you indicated, it is now more than 20 years since Head Start began providing services to children from low-income families throughout the country. And the goal of the Head Start Program remains to improve the quality of life for children and their families through objectives for strengthening each child's physical, social, and mental development.

There have been areas in which Head Start has grown and evolved over the years, and as you noted, from a summer program to a full year program. But the blueprint that was laid down 20 years ago is still with us today. We have provided comprehensive early childhood development services to over 9.5 million children, and just as important, Head Start has had a positive impact on families and on communities.

As you noted, the parents are the primary educators of our children and, therefore, parents of our Head Start children play an important role in our entire program. They participate in the classroom as volunteers, as observers, and as staff, and in fact, many parents and other low-income Head Start staff have been able to rise out of poverty through training supported by the program. Thousands have earned college credits or completed degrees in early childhood development and related fields and are now child-care resources themselves.

The program has had a dramatic impact on the child development field nationwide through the child development associate credential.

And since 1980, Head Start has provided these child development services to 2 million children. The budget has increased from less than $820 million in 1981 to more than $1 billion in fiscal year

1985. And during this period, enrollment in the program has grown from 387,000 children to almost 450,000 children.

I would like to outline briefly three areas where we have some program initiatives that are being undertaken and continued in this fiscal year.

One is a management initiative to analyze our costs and improve the efficiency of the program. That started in 1984, and we plan to continue that. The analysis that we have gone through has been able to improve program quality and increase enrollment.

Second, we funded a number of innovative Head Start Programs in 1985, and they are being continued. They have demonstrated new approaches to meeting the special needs of our children and families, such as homeless families in large cities, and dealing with special dental and hearing problems among American Indian children.

Further emphasis will be placed this year on limiting most children to 1 year of participation in Head Start. While there may be special cases where 2 years are justified, we believe that the benefits of an additional year in the Head Start Program are minimal.

And what we need to keep in mind is that for every child who is enrolled in the program for 2 years, another child receives no Head Start benefits at all.

There are a number of current and pending actions which I understand that you and the committee would like to address. In fiscal 1986, Head Start appropriations included a $12 million increase over 1985. However, Head Start funding will be reduced by 4.3 percent due to Gramm-Rudman-Hollings legislation.

We plan to minimize the effect of this reduction on local grantees by using other discretionary funds within Head Start and allocating those to project grants. Each local grantees, therefore, will receive 1.4 percent less than it received in fiscal year 1985.

Now, in regard to 1987, the administration's budget request of $1.075 billion would allow grantees to be funded at the full 1985 level.

I also understand that you are interested in the possible effects of Gramm-Rudman-Hollings on the Head Start Program: The sequestration, and how that is applied. We do not see any negative effects on the Head Start Program as we expect to serve the same number of children this program year as we did last year.

The major Federal programs that provide assistance to Head Start are the USDA Child Nutrition Program, known as the School Lunch and the Child-Care Feeding Programs, and the Medicaid Program.

USDA programs reimburse Head Start for meals and snacks that are served in center-based programs, and in 1985 that was approximately $100 million. Medicaid, through the early periodic screening and diagnosis, and treatment services to eligible children, currently impacts 47 percent of our Head Start children.

Both Medicaid and USDA programs are exempted from Gramm-Rudman-Hollings legislation, from sequestration. Therefore, we do not expect any negative impact on Head Start from that area.

About half of the Head Start grantees throughout the country are community action agencies, which are funded by the community services block grant. The Community Services Block Grant is

subject to the sequestration order of 4.3 percent in fiscal year 1986. We do not expect this to have any impact on Head Start grantees, all of whom receive Head Start grant funds to fully cover administrative costs and indirect costs and are not dependent on the community action agencies for this support.

For similar reasons, we do not believe that there will be a major impact on the Head Start Program from the administration budget proposals to rescind part of the community services block grant fiscal year 1986 funds and to repeal that block grant in 1987.

We would expect to continue funding those community action agencies which continue as Head Start grantees. Should there be some community action agencies in the future who are not able or willing to continue as Head Start sponsors, then we have a responsibility to find and would find a successor grantee in that community to provide Head Start services. We do not expect any diminution in either quality or enrollment in Head Start should there no longer be a Community Services Block Grant Program.

Nearly half of the current Head Start grantees are not community action agencies, and many of these have lower administrative costs than those grantees connected to community action agencies.

Returning to the USDA and the Medicaid side, the President's budget request for 1987 sustains 1986 service levels, and we therefore do not see negative impacts in that area. There is no proposed reduction in the President's budget for the USDA programs which support Head Start, and we do not foresee any reduction in the level of support provided by Medicaid under the President's proposals.

I would like to reaffirm to you and your committee our commitment to continue providing high quality, efficient, and very responsive services to Head Start children and their families. For this reason, we are here requesting a 3-year reauthorization of the 1984 Head Start Act with only minor program changes. We have proposed the elimination of the provision requiring that at least $25 million be spent each year for training and technical assistance. This change will remove what we consider an unnecessary restriction on the Secretary's discretion to meet program needs.

We also recommend that mandatory cost-of-living increases for Indian and migrant Head Start Programs be eliminated. Mandated increases for these programs place an unfair burden on other Head Start grantees. Our proposal will, however, ensure that Indian and migrant Head Start Programs receive at least the same proportion of available funds as they received in 1985.

Finally, we are concerned about the financial impact on Head Start Programs of the practice by Head Start employees of filing for unemployment compensation during the summer months while Head Start is not in session and then resuming employment when the new Head Start year begins in September.

The charge to Head Start Programs by State unemployment compensation programs in proportion to the usage by employees is becoming an increasing burden on the finances of the grantees. And you will note, in the President's budget request for 1987 we have asked for appropriations language treating Head Start employees as employees of educational institutions for this one specific purpose, and that is making them ineligible for unemployment

compensation on a routine basis during the periodic breaks in employment. We will also be making a request for a similar change in legislative authority.

In summary, we are recommending minor changes but not a significant restructuring of the Head Start Program. We continue our very strong commitment to support and strengthen this important program, and I certainly appreciate your personal interest and our very successful visit to the Miami Head Start Program this past fall.

Thank you.

[The prepared statement of Ms. Hardy follows:]

STATEMENT BY

DORCAS R. HARDY

ASSISTANT SECRETARY

FOR

HUMAN DEVELOPMENT SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

COMMITTEE ON LABOR AND HUMAN RESOURCES

UNITED STATES SENATE

February 27, 1986

Mr. Chairman, and Members of the Committee, I am pleased to have the opportunity to appear before you on behalf of the Department of Health and Human Services to discuss the reauthorization of the Head Start Program. With me today is Dodie Livingston, Commissioner, Administration for Children, Youth and Families, and Clennie Murphy, Acting Associate Commissioner of the Head Start Bureau.

It is a pleasure to request the reauthorization of this important program, with its significant emphasis on economic and social self-sufficiency in our society.

Background

It is now more than twenty years since Head Start began providing services to children from low-income families throughout the nation. The program was launched in 1965, and was designed to follow recommendations made by a panel of experts, chaired by Dr. Robert Cooke of Johns Hopkins University.

They concluded that special programs could be devised to improve both the opportunities and achievements of children living in poverty and noted, "It is clear that successful programs of this type must be comprehensive, involving

activities generally associated with the fields of health, social services, and education, and they must be tailored to the needs of the individual community and the individual child."

The objectives of the Head Start program were defined as:

a. Improving the child's physical health and physical abilities;

b. Helping the emotional and social development of the child by encouraging self-confidence, spontaneity, curiosity and self-discipline;

c. Improving the child's mental processes and skills, with particular attention to conceptual and verbal skills;

d. Establishing patterns and expectations of success for the child which will create a climate of confidence for future learning efforts;

e. Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems;

f. Developing in the child and his family a responsible attitude toward society, and fostering constructive opportunities for society to work together with the poor in solving their problems; and

g. Increasing the sense of dignity and self-worth within the child and his family.

There have, of course, been a number of areas in which Head Start has grown and evolved over the years, such as converting from a short-term summer project to a schedule of eight months or longer, establishing mandatory performance standards to ensure program quality, and reaching new populations like handicapped children. Despite these changes, the objectives laid down more than 20 years ago remain the blueprint for Head Start.

Studies have shown that Head Start is an effective vehicle for providing the services necessary to narrow the gap between impoverished children and their more advantaged peers. In the past twenty-one years, Head Start has provided comprehensive early childhood development services to over 9-1/2 million children and improved the quality of life for these children and their families. Intended primarily for preschoolers from low-income families, the program has fostered the development of children and enabled them to deal more effectively with both their present environment and later responsibilities in school and community life.

Head Start has also had a positive impact on families and communities. Parents of Head Start children participate in classrooms as volunteers, observers and staff, as partners with professional staff in making decisions about their local program, and as recipients of social services, child development information, and other related services they request. Many parents and other low-income Head Start staff have been able to rise out of poverty through training supported by the program. Thousands have earned college credits or completed degrees in early childhood development and related fields and are now child care resources themselves.

In many ways, the program has had a dramatic impact on the child development field nationwide. Head Start has served as a model for many public and private child development programs. It has had a profound influence on the planning of child development and day care services, on the expansion of State and local activities for children, on the range and quality of services offered to young children and their families, and on the design of training programs.

Studies indicate that Head Start children score higher than comparable non-Head Start children in preschool achievement

tests. Studies also show that Head Start children perform as well as or better than their peers when they enter elementary school, and that they have fewer grade retentions and special class placements.

In the past five years, Head Start has provided comprehensive child development services to 2,092,300 children. The budget has increased from less than $819 million in FY 1981 to more than $1.075 billion in FY 1985. During this period, enrollment in the program has grown from 387,300 to 448,250, and specific steps have been taken to improve the quality of the services provided.

Head Start became more effective in working with families during this period. For example, between 1980 and 1985, the delivery of health services improved, with treatment being provided to 97 percent of the children with medical problems, as compared with 87 percent in 1980. Ninety-five percent of the children needing dental treatment now receive it, 5 percent more than in 1980. Today, virtually every child who is in the program for more than 90 days receives medical screenings, and 95 percent receive dental screenings. In addition, 94 percent of Head Start children receive all needed immunizations.

The percentage of Head Start families receiving social services increased from 75 percent to 97 percent. More parents volunteered to help in the program, an increase from 64 percent of all parents to 81 percent. More parents were hired to work in the program, and in 1985 parents constituted 32 percent of Head Start employees. In the classroom, the qualifications of staff have also improved, with 31 percent of staff now having a degree in early childhood education for a Child Development Associate (CDA) certificate. Head Start continues to provide special services to 12 percent of its children who have been professionally diagnosed as handicapped.

I would like to outline briefly for this Committee a few areas in which program initiatives are being undertaken during FY 1986:

- A management initiative to analyze costs and improve the efficiency of programs, which became operational in FY 1984, is continuing this year. Grantees have identified savings through the use of this management analysis and utilized these savings to improve program quality and increase enrollment.

- A number of innovative Head Start projects funded in FY 1985 are being continued in FY 1986. The projects are demonstrating new approaches for delivering Head Start services to meet special needs, such as serving homeless families in large cities and dealing with special dental and hearing problems among American Indian children.

- Further emphasis will be placed on limiting most children to one year of participation in Head Start. While there will be special cases where two years are justified, we believe that the benefits of an additional year in the program are minimal. What we need to keep in mind is that for every child enrolled in the program for two years, another child receives no Head Start benefits at all.

- A network of Resource Access Projects (RAPs) provides local grantees with special training and technical assistance for meeting the special needs of handicapped children.

- We are continuing our commitment to parent involvement in Head Start and are continuing to emphasize the role of parents as the primary educators of their children.

- o A variety of training and technical assistance activities are helping local projects to meet program performance standards in component areas which include education, social services, parent involvement and health services. Services are delivered in part through a network of training and technical assistance providers which are accountable to local Head Start projects, and in part through the direct funding of local programs to allow them to purchase training and technical assistance directly.

Effect of Pending Actions

There are a number of current or pending actions which I understand you would like us to address.

In FY 1986, the Head Start appropriation, which included a $12 million increase over FY 1985, will be reduced by 4.3 percent due to the effects of the Gramm-Rudman-Hollings legislation. However, we plan to minimize the effect of this on local grantees by applying other discretionary funds to project grants. Each local grantee will receive 1.4 percent less than it received in FY 1985. In regard to FY

1987, the Administration's budget request of $1.075 billion would allow grantees to be funded at the full FY 1985 levels.

I understand also that you are interested in the possible effects on the Head Start program of Gramm-Rudman-Hollings sequestration applied to other programs. In summary, we do not see negative effects on the Head Start program.

The major Federal programs providing assistance to Head Start are USDA child nutrition programs (the School Lunch Program and the Child Care Feeding Program) and the Medicaid program. The USDA programs reimburse Head Start for meals and snacks served in center-based programs. In FY 1985, the reimbursement was approximately $100 million. Medicaid's Early Periodic Screening Diagnosis and Treatment program (EPSDT) provides screening, diagnosis and treatment services to eligible Head Start enrollees, currently 47 percent of Head Start children.

Both Medicaid and the USDA Child Nutrition programs are exempted by the Gramm-Rudman-Hollings legislation from sequestration. Therefore, we do not expect any negative effects on the Head Start program.

About half of Head Start grantees are community action agencies funded through the Community Services Block Grant (CSBG). The CSBG is subject to the sequestration order of 4.3 percent in FY 1986. We do not expect this to have any impact on Head Start grantees, all of whom receive Head Start grant funds to fully cover administrative costs and indirect costs, and are not dependent on the community action agencies for this support.

For similar reasons, we do not believe there will be a major impact on the Head Start program from the Administration budget proposals to rescind part of the CSBG FY 1986 funds and to repeal the CSBG in FY 1987. We would expect to continue funding those community action agencies which care to continue as Head Start grantees. Should there be some community action agencies not able or willing to continue as Head Start sponsors, a successor grantee would be found in the community to provide Head Start services. We do not anticipate any diminution in either quality or enrollment in Head Start should there no longer be a CSBG program. Nearly half of the current Head Start grantees are not community action agencies, and many of these have lower administrative costs than those grantees connected to community action agencies.

Returning to USDA Child Nutrition and Medicaid, the President's budget requests for FY 1987 sustain FY 1986 service levels and we therefore do not see negative effects. There is no proposed reduction in the President's budget for the USDA programs which support Head Start. We also do not foresee any reduction in the level of support provided by EPSDT under the President's proposals.

Reauthorization Proposal

Mr. Chairman, I would like to reaffirm to you and the other Members of the Committee the commitment of the Office of Human Development Services and the Administration for Children, Youth and Families to continue providing high quality, efficient and responsive services to Head Start children and their families.

For this reason, we are requesting that the 1984 Head Start Act be reauthorized for three years, with only minor program changes. We will propose the elimination of the provision requiring that at least $25 million be spent each year for training and technical assistance. This change will remove an unncessary restriction on the Secretary's discretion to meet program needs. We also recommend that mandatory cost-of-living increases for Indian and migrant Head Start

programs be eliminated. Mandated increases for these programs place an unfair burden on other Head Start grantees. Our proposal will, however, ensure that Indian and migrant Head Start programs receive at least the same proportion of available funds as they received in FY 1985.

Finally, we are concerned about the financial impact on Head Start programs of the increasing practice by Head Start employees of filing for unemployment compensation during the summer months while Head Start is not in session, and then resuming employment when the new Head Start year begins in September. The charge on Head Start programs by State unemployment compensation programs - in proportion to usage by employees - is becoming an increasing burden on the finances of the grantees. You will note that the President's budget request asked for appropriations language treating Head Start employees as employees of educational institutions for this one specific purpose, that is, making them ineligible for unemployment compensation during periodic breaks in employment. We will also be making a request for a similar change in legislative authority.

Conclusion

In summary, we are recommending minor changes but not significant restructuring of the Head Start program. We continue our strong commitment to support and strengthen this important program.

We will be happy to answer any questions you may have.

Senator HAWKINS. Thank you.

I have heard a lot about the liability insurance problems in child care. One lady told me that the insurance for her center had quadrupled last year. The East Coast Migrant Head Start Program almost had to close its Florida Head Start programs in February because they could not get any insurance.

How is the liability insurance crisis affecting Head Start nationally, and how is the increased cost of the insurance getting reflected in our budgets?

Mr. MURPHY. Senator, we do have an increase in the cost for liability insurance. We think we have turned the corner on this particular problem in Head Start. We will be sending out an information memorandum to all grantees, explaining our policy for liability insurance.

In addition to that, we will be working with each grantee to discover what would be a reasonable cost for liability insurance, with the rates going up. We will be working with grantees on a grantee-by-grantee basis, and in some cases, we will be able to help them to supplement their budgets in this case. You know the insurance problem is an insurance problem across a number of other programs, but we have been working very closely with the insurance industry. We have been trying especially to explain to them what Head Start is about. We have parents in and out of our centers; we have performance standards, we have clear expectations. And we really have not had any major problems in terms of legal cases.

Senator HAWKINS. No. And I feel that the insurance companies are wrong, because there is no data that backs up what they want to charge.

Mr. MURPHY. Well, our position is that there is no evidence in the Head Start Program that we have caused an undue burden on insurance companies.

Senator HAWKINS. That is right. A national study that monitored centers said that even day-care centers do not reflect the abuses that some people are saying they do.

Could we have a summit with some of the insurance companies? I know many of the presidents of those companies. I think that just because insurance is high, across the board, it ought to reflect actual case history. I would be more than happy to do it for Florida, but as chairman of this subcommittee, I think it is very important that we do it nationally. You know, any penny we can save, we need to give it to the children and not to the insurance companies.

Mr. MURPHY. Yes.

Ms. HARDY. Right.

Mr. MURPHY. We have identified an insurance company that is working with us very closely at this point, Continental Insurance Co.—I guess everybody will call them after this comment. But we have found an insurance company that is working very closely with us.

The problem, as you mention, is beyond Head Start; it is other day-care centers as well. But we will continue to have the meetings.

Senator HAWKINS. Yes, but I am talking about Head Start today. I do not want Head Start to get caught up in this day-care problem.

We should have a separate understanding. We should bring the statistical data to insurance companies and make sure each State understands this separation. If you have to have a summit with the 50 insurance commissioners, if there is such a thing, then do it.

Mr. MURPHY. Yes.

Ms. HARDY. We have thought about that, but also, as we are moving along with Continental, I think that may solve at least the Head Start problem. So, we are very pleased to be working with them at least at this moment. And that would provide access nationwide to a company that has legitimate rates——

Senator HAWKINS. How do you do that? Do you send a bulletin to each Head Start Program after you work out this——

Ms. HARDY. Yes.

Senator HAWKINS. Will Continental become sole source?

Mr. MURPHY. Well, no. The local programs contract with the various insurance companies. They have a very good network, so when they find out that one insurance company is writing, they basically deal with that insurance company.

The National Association——

Senator HAWKINS. Aren't they restricting themselves to 4 percent of the national child-care market, Continental? Didn't I hear that somewhere?

Mr. MURPHY. I am not aware of that.

Senator HAWKINS. Well, would you find out?

Ms. HARDY. Yes, Senator.

Senator HAWKINS. Ms. Hardy, in your testimony you indicated Head Start is working with homeless families. Could you describe that program?

Ms. HARDY. The city of New York had discussions with us I guess about 18 months or so ago, to let us know that there are some families living in what they call the welfare hotels. And we had felt that perhaps there might be a way to get access to those children for child care and for the Head Start Program. So we have a small research grant with the Human Resources Administration in New York City which targets on I believe two or three of the welfare hotels and integrates those young children, Head Start eligible, into the local Head Start Program.

So I think it is also seen as an outreach effort as well—those children are integrated into the program and our funds provide for the outreach to those areas.

Senator HAWKINS. I understand that you are giving a demonstration grant for bridging children from Head Start into public schools?

Ms. HARDY. Yes.

Senator HAWKINS. Do you personally feel this is an alternative to the Follow Through Program?

Ms. HARDY. We did not see it as an alternative to Follow Through. What we saw is that in studies of Head Start, one of the areas where we need improvement is that transition from that child spending 8 or 9 months in Head Start and then starting out with equal Head Start when they get into kindergarten or first grade.

We have put out an announcement, and it is currently being competed, of basically Head Start programs throughout the coun-

try for small, 2-year grants that would work closely with the public schools. We are kind of excited about it and feel that if we can cover the country with some demonstrations then we can use those models to reach out to the rest of the country.

Dodie, do you want to answer that?

Senator HAWKINS. Well, I am concerned about the loss of data from Follow Through because we have been following these children in that Follow Through Program.

Ms. LIVINGSTON. We have no intent of in any way hampering Follow Through. But one of the important pieces of this project, which we call Sister Schools, is also to get the parent transitioned effectively, because as you know, we consider the parent to be the prime educator of the child, and if the parent or the parents are given information on how to work effectively with the new school—with the PTA, with the principal, the teacher, and they know the campus—then we feel we are many steps ahead.

So it kind of includes all those components.

Senator HAWKINS. The one way to evaluate whether Head Start is truly making a difference to children in poverty families is to continue to collect the valuable data that we have in following these children through. So we would hate to see that drop by the wayside if it is not reauthorized as a separate program.

Mr. MURPHY. Senator, if I may comment on Follow Through, our children only move into the Follow Through Program where Follow Through programs are in those communities.

Senator HAWKINS. Sure.

Mr. MURPHY. And the program that we are talking about—since Head Start is so comprehensive, what we want to do is make sure that our health records are transferred to the schools; we want to make sure that the curriculums are somewhat compatible, and I think the parents are the overriding factor here. We want to make parents comfortable with the public scbools, and also to bring the public schools to Head Start and to give them some feel of what is happening in Head Start and to define what an aggressive kid is and to say that that is positive. All of those are factors in this effort.

So we still see Head Start as demonstration, looking at various areas of demonstrating how to deliver those services that were started back 20 years ago. So this new project is in no way diminishing the effort that we are involved in when we are in communities with the Follow Through Program.

Senator HAWKINS. I would like to commend you, Dorcas, for sustaining the first round of Gramm-Rudman cuts without significantly cutting services in this program, and I have some more questions along that line of thought for next year.

I would like to welcome Senator Grassley, a member of the subcommittee, here, with his statement and some questions, and also Senator Kerry.

Senator GRASSLEY. I only have two questions of Ms. Hardy. I would like to ask you to give us an update on your parental involvement program, but before you do that, I want to read just two lines from my opening statement. I am not going to read the whole statement.

Nationally statistics show that for every 15 children in the program, 10 parents volunteer services to their local projects. Now, in my State, we have logged in in 1984 and 1985, 220,000 hours of volunteer services to the program, which in dollar terms, using just the minimum-wage rate, would be the equivalent of $737,000. Now, I do not know how Iowa ranks. I would imagine we rank well. But I am not asking you to comment on that. I would just like to have you give me the national perspective of your Parental Involvement Program.

Ms. HARDY. Well, there are many aspects to our parental involvement program, Senator, one of which is the volunteer component. We want to have the parents intimately involved with that child at the place of Head Start delivery.

We also want, as we were talking earlier, to have a followup at the home so that we really get the parents realizing that it is very important for the child's development that the parents be involved, that they cannot just leave the child's development up to someone else.

In terms of the volunteers, 63 percent of our volunteers were parents, nationwide, and that represents about 420,000 volunteers. So your numbers in Iowa are right along with a very high component of all of the parents—most of the parents—getting involved with the program, and that is certainly something that has been emphasized very heavily and has been one of the cornerstones of the Head Start Program.

Senator GRASSLEY. Can we Republicans through this administration take credit for any innovations in this area of parental involvement and any initiatives different from the previous 15 years?

Ms. HARDY. I think we can take credit for a very long laundry list of a lot of excellent parts of Head Start, not the least of which is parent involvement.

Senator GRASSLEY. What about new directions?

Ms. HARDY. We have some new models that we have that we can supply to you for parental involvement. We also have a new program that we are starting this spring called the Parent Enrichment Program, the acronym of which is PEP, and that will be started in 12 or 15 Head Start throughout the country, one of which will be in Des Moines, IA. We believe that by getting the Head Start parents very much involved and the Head Start directors with the Head Start parents and an adult literacy component, that that will be to everyone's benefit. I really want all the parents to be able to read to their children.

Senator GRASSLEY. Have you reduced Head Start funding more than the 4.3-percent required by Gramm-Rudman-Hollings?

Ms. HARDY. No, sir, no.

Senator GRASSLEY. Thank you. I appreciate your answers, and I have no further questions.

Thank you, Madam Chairman.

Senator HAWKINS. Thank you.

Senator Kerry.

Senator KERRY. Thank you, Madam Chairman.

I would just like to ask unanimous consent that a statement be inserted in the record, and I will not make a formal statement.

Senator HAWKINS. Fine.

Senator KERRY. But I would like to thank you for having this hearing. I think it is an important program to be airing our thoughts about. I regret that, as usual around here, we all have five different hearings we have to go to, and unfortunately, I cannot stay as long as I would like to. I hope the witnesses will understand it is not a lack of interest, but an effort to try to spread interest.

I want to see us reauthorize this at the Stafford recommendation level. And if I had my way, we would put more money into this kind of effort.

I think it is significant that, though we are serving somewhere around half a million kids, we are only serving about 18 percent of those people who are eligible. And it seems to me totally inconsistent for the Congress as well as for the administration to be talking about increasing our ability to compete with other countries and to have an educated society and to give kids the best of opportunity at the same time as we continue recognizing we are only serving 18 percent of the people we ought to be. And somehow, I think that issue has got to be addressed, and we have got to think about it.

But this program obviously is a success at least by most measurements. There is some conflict on that. I think since 1970, there have been something like 1,500 studies or so of the program, almost—almost—all of which point to a majority of successes.

So let me really just ask you a couple of questions if I can which address this issue about what we ought to be doing.

The current request of the administration is for the 1985 level. And I wonder why, given the recognition of the serious administrative problem around the salary and the base of the $8,600-some, and the summer unemployment problem, and the clear administrative difficulties which it seems to me people recognize that come from that, why are we satisfied saying that—and given the 18-percent eligibility service level—why are we satisfied coming in at an 1985 level? What is the rationale?

Mr. MURPHY. Senator, over the past couple of years in fiscal years 1984 and 1985, we have received a total increase of somewhere in excess of $150 million into the Head Start Program. In that effort, we have made a concerted effort to expand the Head Start Program, to put certain management efficiency efforts in place. We needed a year to stabilize the program to make sure that we were reaching adequate enrollment, to review our cost studies in each program, to indicate that they were using their moneys effectively.

We have a system by which we are fortunate enough to be able to carry over dollars spent in one year to the next year. We call that carryover balance.

We have been making a concerted effort over the past year to reduce that carryover balance, translate it into items that will meet those issues you talked about such as administrative costs, helping with salaries. So we felt that we needed this year of fiscal 1987 to put our house in order.

Ms. HARDY. Senator, let me emphasize what Mr. Murphy has said. The program has grown substantially since 1981. We have added more than 75,000 children per year, and we have done that in increments. And we believe that as we look to 1987, given the

fiscal constraints, given where we are all trying to go, that we can serve approximately 450,000, maybe a few more, children in 1987.

Senator KERRY. How many more? I missed that number.

Ms. HARDY. We can probably serve a few more than 450,000 children in 1987 with the same amount of dollars, because of what Mr. Murphy was saying of carryover balances, of administrative discussions, et cetera.

Senator KERRY. But will the teachers' salaries be increased?

Mr. MURPHY. The salary schedule, Senator, is a very complex problem for us, simply because salaries are set by local communities. We are in the process of trying to put in place a system for looking at wage comparability studies in each community, with the dollars we have on hand now and with those studies, beginning to look at the area of salaries.

It is a very crucial issue for us. We realize the importance of it. We have to look at comparability. There is really nothing comparable to Head Start out there in the community. So we are taking a look at the public school systems; we are taking a look at child care, and then we are taking a look at what we offer in Head Start.

Thirty-two percent of our staff are parents, and we encourage upward mobility. So we are trying to put that process in place. We will be talking about our Child Development Program.

We see a need to offer incentives for this. We see a need to help those local programs who are doing a good job. So we do see a need in this area. We are trying to at this point put certain administrative procedures in place so we can do a better job of really analyzing where we are in terms of salaries.

Senator KERRY. I noticed that in conjunction with dealing with these administrative problems that the $25 million that was set aside for teacher training is taken out.

Ms. HARDY. No—well, we have $25 million which is earmarked to be spent on training and technical assistance, and that is certainly there.

What we are suggesting for reauthorization is that we have the flexibility to use that and to not have that earmarked, that it has to be $25 million.

Senator KERRY. I understood that. I guess I did not finish my question. If you are given more discretion as you have requested, will additional money be spent on teacher training?

Ms. HARDY. We have a significant commitment to get the best quality in terms of our teachers through the child development associate credential. That does take dollars from the Federal Government, and we will continue to commit ourselves to that. If I remember the figures, it is about $15 million of the $25 million that is spent on child development associate credential, either directly or funding the Head Start programs to buy that credential.

I think we are looking to a time when we can get many of our teachers into that credential program. The credential program has now grown to 15,000 nationwide, and that would be a way in which we would be looking at enhanced salaries for an individual who has that CDA credential.

So we would be committed to keeping that CDA.

Senator KERRY. Just one last question. With respect to other areas of criticism or concern that people have had over the years,

notwithstanding the great success of the program, I guess most specifically the issue of greater cooperation between the elementary schools and providers—I think you mentioned that briefly—and second, more emphasis on educational activities and more attention to preparing kids for school—I think those have been the three areas outside of parent participation which was mentioned by Senator Grassley.

Are you addressing each of those, and perhaps you might just touch very quickly on what is happening there.

Ms. HARDY. I will let Commissioner Livingston answer that, but let me just precede by saying we are aware that we have to do more in the educational involvement area, and that has come through recent studies, and we really want to concentrate more in that area.

Dodie.

Ms. LIVINGSTON. Yes, we are. Part of the transitioning project that we mentioned earlier is a piece on curriculum. We are not in a position to tell the public schools what to do with their curriculum, but we want to have what we do in Head Start mesh with the curriculum there. And we have a curriculum evaluation study going on in Head Start right now, looking at the curriculum. We have some curriculum guides and teaching manuals that we are developing with a whole task force to try to strengthen that piece within the constraints of what 3- to 5-year-old children are able to do.

Also, you were kind of excluding the parent piece from your question, but I would like if I could to bring that back in.

We have a national parent task force specifically assigned to study parent involvement in Head Start. It was appointed almost a year ago, and it will be reporting within a few weeks. We are now working on the draft of the report. And the idea of that was not to say that parental involvement does not work, because we know it does work, but to look at everything that is happening across the country and see how we can make it work better.

And we have had a task force of about 10 people, including all the components of Head Start, the staff, the directors, the National Head Start Association, the Indian programs, the migrant programs, our central office staff. It has been a very, very exciting project. We have had four meetings of the task force, and the meetings have just been really a lot of fun. So we are looking forward to——

Senator KERRY. A meeting that is fun. That is a new thing.

Ms. LIVINGSTON. Ask Sarah when she testifies. Sarah has been a key member. And I think it is the feeling of doing something positive for people who need a hand and to motivate them more and to help those who are motivated to go further. So we are very excited about that.

We feel like we kind of have a big picture here that is evolving nicely, and we are quite proud of it.

Senator KERRY. Well, I wish you well, and this might be incongruous, but I hope we can give you a little more money than you asked for.

Thank you, Madam Chairman.

Senator HAWKINS. I have other questions for the panel, but I will submit those in writing, since we are pressed for time.

We thank you very much, Ms. Hardy. We are very proud of your direction and the leadership you have given this program.

[Responses of Ms. Hardy to questions submitted by Senator Hawkins follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of
Human Development Services

Assistant Secretary
Washington DC 20201

MAY - 6 1986

The Honorable Paula Hawkins
United States Senate
Washington, D.C. 20510

Dear Senator Hawkins:

This is in response to your letter of March 5, 1986, requesting additional information on the Head Start program. Our response follows each of the questions that were contained in your letter.

1. Would you provide the average hourly wages for teachers, teacher aides and parent aides for Indian programs, for migrant programs, and for programs that do not include Indians and migrants?

   ACYF does not collect information routinely on average hourly wages. However, in 1985 the Office of the Inspector General, DHHS, completed a survey of wage comparability between Head Start and day care agencies in the same community. Data on hourly wages were collected from 62 Head Start projects. The survey found that the average hourly wage of Head Start teachers was $5.41 while the average hourly wage of Head Start teaching aides was $4.32. No separate data was collected for Indian or migrant programs. No separate data was collected on parent aides who, in most cases, serve in the classroom as teacher aides or work in other Head Start component areas such as health, parent involvement, or social services. The Inspector General's survey found that average hourly wages for Head Start teachers and aides were higher than the average hourly wages of their counterparts in day care agencies in the same community.

2. The President's Budget for FY 1987 states that Head Start grantees shall be considered as educational institutions under the Federal Unemployment Tax Act. What are the legal ramifications? How does DoL view this change?

On March 31, the Department sent to the Congress its proposed legislation for reauthorization of the Head Start Act, including a proposed change in the authorizing statute making Head Start employees ineligible for unemployment compensation during periodic breaks in unemployment. This proposal was developed in coodination with the Department of Labor.

The proposal defines all Head Start grantees as educational institutions within the meaning of section 3304(a)(6)(A) of the Federal Unemployment Tax Act, thus making all Head Start employees (including those employed by community action agencies and other nonprofit organizations other than schools) ineligible for unemployment compensation during between-term breaks in employment. This amendment would ensure that all Head Start staff are treated in the same way as Head Start employees in public school systems, who are already prohibited from collecting unemployment benefits between terms.

3. What are your contingency plans should Gramm-Rudman-Hollings require a 20% budget cut next year?

The President's budget request for FY 1987 meets budget deficit reduction targets while maintaining the Head Start budget at its pre-Gramm-Rudman-Hollings (GRH) FY 1985 funding level. If the President's budget is adopted, Head Start would face no budget cuts. However, if Congress cannot meet its budget reduction targets for FY 1987, thereby triggering GRH cuts in FY 1987 at the 20 percent level you project, we would need to decide which of several possible options for implementing such a cut would be the least disruptive for Head Start. These options range from implementing the reduction uniformly across all programs to using a variety of quality and cost factors to determine the most equitable way to allocate the resources available.

4. Close to one-third of all Head Start children stay in the program for a second year. What is your commitment to allowing that trend to continue? Given that Head Start is designed to reach families most in need of services, how can you help such children escape the cycle of poverty if you abolish the second year of service of Head Start children?

We are very confident that one year of Head Start results in tangible benefits for disadvantaged children. At the same time there is little or no evidence that one or more additional years of Head Start provide additional gains which can justify multiple years of Head Start for some as a standard practice while depriving other eligible children in the same community of even one year of Head Start.

ACYF is not proposing, however, to limit Head Start services to one year for all children. We recognize that some children, e.g., the handicapped, may need multiple years of Head Start, and local programs can determine when a second year is required based on individual cases. However, we do not believe that multiple years of Head Start as a standard practice is appropriate while there are unserved eligible children in the community who we know would benefit from a single year of Head Start.

To put the significance of this issue in perspective, if the percentage of children receiving Head Start for multiple years was reduced to 15 percent of the current enrollment of 448,250, the percentage of eligible children actually benefiting from a Head Start experience in the year before entering public school could increase to over 40 percent of the eligible population.

5. Would you please elaborate on the evidence you have that the benefits of two years in Head Start, as compared to a single year, are minimal?

Our position that multiple years of Head Start as a standard practice within programs cannot be justified is supported by several extensive reviews and analyses of relevant research in the Head Start and preschool education fields, e.g.,:

- o In 1977 the findings of fourteen important longitudinal studies of low-income children who participated in experimental infant and preschool programs were assessed by the Education Commission of the States and ACYF. One principal finding was that preschool programs "produce a significant increase in the intellectual functioning of low-income children at least during the critical years of the primary grades in school." However, "programs which had significant effects ranged in duration from eight months to three years and... there is no indication of a most effective length of intervention." Furthermore, the report concluded that the "data in this report do not clearly indicate that...a particular length or type of preschool experience is optimal for all children." 1/

- o From 1982 to 1985 a thorough compilation and analysis of 210 Head Start research and evaluation projects published since 1965 was undertaken through a contract from the AYCF. 2/ A number of positive impacts of participation in Head Start were identified. However, the studies indicated that children who enter Head Start at three, most of whom stay in Head Start for more than one year, do not show more or better cognitive gains than children who start Head Start at age 4, most of whom are in Head Start for only one year.

1/ Education Commission at the States, THE PERSISTENCE OF PRESCHOOL EFFECTS: A Long-Term Follow-up of Fourteen Infant and Preschool Experiments. [Wash.:GPO], 1977, 114 pp. and Appendices.

2/ McKey, R.H. et al. FINAL REPORT OF THE IMPACT OF HEAD START ON CHILDREN, FAMILIES AND COMMUNITIES. HEAD START EVALUATION, SYNTHESIS AND UTILIZATION PROJECT. Wash: CSR, Inc., 1985. Contract No. 105-81-C-026.

Seventy-five percent of Head Start children currently receive only one year of Head Start and these children show significant gains in their socio-emotional development and cognitive skills.

Because of special needs, it will continue to be appropriate to serve some Head Start children for more than one year, and Head Start will continue to provide multiple years of service based on the needs of individual children. Our program information, however, indicates that decisions regarding multiple years of service are not always being made on the basis of an individual child's need, and multiple years of service are not being considered when determining program content. For example, many programs serving children for multiple years do not provide differentiated curricula that meet the needs of the child who is in the program for a second year, and that build on the child's first year learning experiences during the second or third years of service. Basically, the child gets a repeat of the first year.

6. You have requested that the earmarking of funds for training and technical assistance be removed. There is a large personnel turnover in Head Start programs. If the earmarking is removed, how can we be assured that adequate training and technical assistance will occur? How can we be sure that this will not be one of the first areas to disappear if there are budget cuts?

We recognize the importance of training and technical assistance (T/TA) to the Head Start program and certainly have no intention of eliminating this activity. We would like to point out that the statutory requirement that an adequate amount of T/TA be provided to support program functions will remain - we have not asked that that provision be deleted.

We see an on-going need to provide resources for the training of Head Start staff and for the technical assistance needed for program improvement. We do believe, however, that the earmarking of T/TA funds inappropriately restricts the ability to shift funds within the Secretary's discretionary authority to best meet program needs.

7. Will serving more children really be effective if the quality of the Head Start program is greatly diminished because of cuts in teachers and teacher aides?

We do not plan to reduce the quality of the Head Start program or the number of teachers and teacher aides. Our desire to serve more children stems from our recognition that many eligible children are not being served by Head Start. We believe it is important to give as many children as possible the benefits of a Head Start experience.

We recognize, however, that one of the most important factors making Head Start the premier early childhood program in the country is the quality and commitment of its employees. We will continue to assure that Head Start attracts and retains qualified classroom staff.

8. Head Start programs frequently coordinate with other Federal programs, such as the Foster Grandparents program, at the local level to help provide services to children and families. Are there any Federal programs with which the Head Start program could coordinate in order to help with the provision of services? Please review programs that are in the Department of Health and Human Services, but also please include programs that are administered by the Department of Education, the Department of Labor, ACTION, or other Federal agencies.

We constantly urge our Head Start grantees to coordinate with as many other human service organizations as possible in order to extend services and avoid duplication of effort. To that end, we have interagency agreements with:

Department of Agriculture: Child Care Food Programs provide reimbursement for food and food services and the USDA Extension Service provides the Nutrition Education Service to children and families. The School Lunch Program provides reimbursement for up to two meals and snacks for each child.

Department of Labor: The Employment and Training Division gives priority to Head Start personnel and parents for training slots designed to improve the competency of child care workers in connection with the Job Training Partnership Act (JTPA).

Health and Human Services: The Public Health Service provides training and technical assistance to Head Start programs. The Medicaid program of Early Periodic Screening, Diagnosis and Treatment (EPSDT) serves approximately 47 percent of all Head Start children and is the major mechanism for treatment of health needs.

Department of Education: The Bureau of the Handicapped has Interagency Agreements with States to assess Head Start children suspected of having handicapping conditions and to provide services. In addition, Head Start recruitment efforts are enhanced by close cooperation with Child Find services.

9. How can coordination between the Head Start program and the training programs under the Job Training Partnership Act be improved?

In response to identified needs in Head Start programs and in order to improve coordination, the following activities are in place:

ACYF and DoL have developed an Interagency Agreement which facilitates the use of JTPA resources for the training and assessment of child care providers, including Head Start staff.

At the regional level this interagency agreement between DHHS and DoL has been further refined in conjunction with State agencies in our ten regional offices. In addition, local Head Start grantees are developing strategies with Private Industry Councils, community colleges and other local preschool programs such as day care.

In conjunction with the CDA National Assessment and Credentialling Office, we are disseminating quarterly newsletters on JTPA and other training activities to community colleges, Head Start grantees and other interested preschool projects and training contractors.

ACYF funded six innovative training proposals from Head Start grantees during our 1985 expansion effort. These grantees will be training parents and staff for child development positions using JTPA funds when possible and networking with the local colleges to develop even larger pools of trainees.

ACYF plans to fund approximately fifteen grants to community colleges to train Family Day Care providers. A number of these colleges will be tying services to JTPA funds so that ongoing training and a constant supply of students will be assured.

10. In testimony, you have stated that organizations other than CAAs often operate Head Start programs at a lesser administrative cost than Community Action Agencies. Could you provide the Subcommittee with either a copy or a description of the data on which that finding is based? Also, could you tell us if the comparison of administrative costs was controlled for such variables as class size, distances to be travelled, the availability of free health services, and others? And, finally, could you tell the Subcommittee if the statement could be turned around so that it would be fair to say that CAAs often operate Head Start programs at a lesser administrative cost than other programs, such as those operated by public school systems?

In testimony, we tried to specify that some CAAs have higher administrative costs than programs operating under other auspices. In cases where CAAs are charging the Head Start program a high indirect cost rate, a higher administrative cost is often the case. The data below indicates, however, that especially for public CAAs, a lower administrative cost than other program auspices is possible. To date, no statistical analysis controlling for such variables as class size, travel and health costs has been implemented.

The cost data available to us indicate the following breakdown of average administrative costs by program auspice. It is based on cost analysis data over a three year period for more than 400 grantees and delegate agencies. The data is derived from determining, for each grantee and delegate, the amount of administrative cost in each line item of their budget. (These figures are based on ACYF dollars only. Since non-Federal share is not included, the administrative cost percentages seem to be above the 15 percent statutory limit.

However, if the minimum non-Federal share of 20 percent of total costs is figured into the calculations, all the following auspices would be below the 15 percent statutory limit for administrative and developmental costs.)

National Average:	16.6%
Public CAAs:	15.1%
Private CAAs:	17.0%
School Systems	15.8%
Non-Profit Organizations	17.4%
Local Governments	16.5%
Other	17.0%

I hope the above information will be of help to you.

Sincerely,

Dorcas R. Hardy

Dorcas R. Hardy
Assistant Secretary
for Human Development Services

Senator HAWKINS. The next panel includes Ms. Sarah Greene, president of the National Head Start Association. Ms. Greene works with Head Start in East Bradenton, FL.

The second panelist, Dr. Mary Ann Hutchison, is project director for the top-rated demonstration and research discretionary grant in fiscal year 1984. She will be reporting on the results of her study entitled, "Strengthening Head Start Families; Reducing High Risk Through Mental Health Prevention." The study was conducted at the Latin American Civic Association Head Start Program.

The third panelist will be Dr. Marilyn Smith, executive director of the National Association for the Education of Young Children. Dr. Smith's association recently took over the supervision of the Child Development Associate Program, which offers a valuable part of the training for Head Start personnel, the CDA that we have been discussing with previous witnesses. We are interested in learning about the changes that have gone on in this program since the transfer. She is accompanied by Dr. Carol Ann Phillips.

I will hold my questions until after your summaries of your statements.

Welcome, and we will start with Ms. Greene.

STATEMENT OF SARAH M. GREENE, PRESIDENT, NATIONAL HEAD START ASSOCIATION, EAST BRADENTON, FL; DR. MARY ANN HUTCHISON, PROJECT DIRECTOR FOR STRENGTHENING HEAD START FAMILIES, LATIN AMERICAN CIVIC ASSOCIATION HEAD START, LOS ANGELES, CA, ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION; AND DR. MARILYN M. SMITH, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION FOR THE EDUCATION OF YOUNG CHILDREN, WASHINGTON, DC, ACCOMPANIED BY DR. CAROL ANN PHILLIPS

Ms. GREENE. Thank you, Senator Hawkins.

Good morning, and I am Sarah, president of the National Head Start Association, and I am from sunny Florida.

We appreciate the opportunity to testify today on the reauthorization of Head Start. We welcome the strong support for Head Start and other key children's programs such as Child Nutrition, Child Abuse, School-Age Child Care and resource and referral programs from you, Senator Hawkins.

The next 2½ pages give many of the successes of Head Start, and we do want that to be a part of the testimony. But I will move on to page 3, the very last paragraph, to begin reading my testimony.

There has been a growing interest in a number of States in early childhood development programs. Last year, Maine made almost $2 million investment in Head Start to enable every county to serve 20 percent of eligible children. Washington State has authorized but has not yet provided funding for a law that would provide State funds for programs which meet most important criteria similar to those which have led to Head Start's success. Illinois will spend $12.1 million and South Carolina, $5 million for preschool programs.

However, we cannot depend on State efforts to fill the gap that exists between the children who need Head Start and those who are able to receive its vital services. In the South, many of our

States have only recently funded kindergarten programs. Mississippi is just now appropriating State funds for kindergarten. Child care is also not faring so well.

In 1986, Alabama plans to eliminate child care services for all children except for those—approximately 350 children—who have been placed in protective custody by the court system.

In 1985, Virginia provided child care for 48 percent of the children that it served in 1981. Georgia and Louisiana are seriously considering reducing State support for child care.

State funding for preschool is not a pressing agenda item in these States as well as in many others.

State-funded early childhood development programs will never substitute for a strong Federal Head Start Program for another significant reason. Most are not able to reach low-income children and families in the same way that Head Start Programs can. Many of the new initiatives do not offer the comprehensive services that are necessary to effectively help low-income children and families. Rather, they focus narrowly on education, which is only one of our program's components.

The reasons for a comprehensive approach are grounded in common sense. Children who miss breakfast and have little to eat during the rest of the day will have a difficult time concentrating in school and will generally fail to thrive.

We reach families in so many ways. Programs provide parents with extensive, structured training in early childhood development. This not only assists them in their own parenting, but acts as a ladder to permanent jobs in Head Start. Some programs go beyond adding components such as computer training, which ultimately gives parents on AFDC the skills to seek jobs outside of Head Start.

It is difficult to capture on paper the scope of our commitment to families. It ranges from sponsoring shared meals to counseling on a group or one-on-one basis, holding small group discussions on child abuse, economics, or meal planning, helping families to find housing, arranging transportation, and supporting families through special periods of crisis to countless other tasks in countless communities.

Our comprehensive approach is not the least costly route to providing services, but if we skimp on any component, children and families will pay the price. We must keep Head Start intact.

Legislation reauthorizing Head Start in 1984 addressed several very important areas, including (1) providing continued Federal funding for the CDA. The CDA credential is a vital one for Head Start teachers to strive for, as it helps to guarantee that they are skilled in a range of competencies essential to quality caregiving. Guaranteeing the $25 million intact for Head Start training. Research is clear that training is intimately linked to the quality of child care. We must continue to invest in training as well as the CDA for several reasons. The Head Start staff is composed of a large percentage of parents, many of whom have not had the opportunity for formal child care training. The extraordinarily high turnover which characterizes Head Start as well as other child care programs also makes training a constant need.

Another area is strengthening the language surrounding Head Start's important performance standards to insure that programs

will be held accountable to a comprehensive set of effective standards, and last, allowing programs the opportunity to provide more than 1 year of Head Start service to children in their communities. We all realize that with such limited resources, it is the key to be able to provide as many children as possible with the benefits of a Head Start experience. However, some children and families need help so desperately that 1 year is not enough to make a difference in their lives.

These changes help to protect the continuing quality of Head Start services and guarantee that the program would be able to reach out with extra support to help our neediest families.

Other issues remain that are difficult to address with diminishing resources. These concerns threaten both the quality of Head Start and its ability to serve additional children.

Head Start salaries are very low. Insurance has also added yet another factor to the painful tradeoff programs constantly struggle with.

We must reauthorize Head Start, the Community Services Block Grant, and the Low-Income Home Energy Assistance Program.

In two programs in Florida—in Orange County, Orlando, FL—the Community Action has an integrated system of staffing. Staff are paid from all of the various programs that they operate. One of the greatest assets to Head Start is their outreach. During the summer when Head Start is closed, it is the staff of the Community Action Agency that recruits and works with the parents and other family members that are not members of Head Start, with 2- and 3-year-olds, the kids that are older, and other people in the family that are not yet in Head Start.

In Tri-County, Bonafet, FL, the Community Action Agency is the transportation provider and as such provides transportation for the Head Start children and parents to the various other programs such as WIN, JEPA, et cetera.

We urge that reauthorization happen quickly so as not to be caught in the press of last-minute business. It is time to express confidence in Head Start by approving a 5-year reauthorization. It is also time to recognize the value of Head Start experience for children and families and to provide for authorization levels that would allow for a $200 million increase during each of those years. If these funds were appropriated, we would still not even serve 50 percent of eligible children in 1991. We share Members of Congress concern with the rising deficit. However, we cannot mortgage our Nation's future. We urge you not only to move ahead to reauthorize Head Start, but also to reconsider the Gramm-Rudman approach to the hard budget choices we must make as a nation.

Thank you.

Senator HAWKINS. Thank you.

[The prepared statement of Ms. Greene follows:]

TESTIMONY ON THE

REAUTHORIZATION OF THE HEAD START PROGRAM

FOR THE

SENATE COMMITTEE

ON

LABOR AND HUMAN RESOURCES

SUBCOMMITTEE ON

CHILDREN, FAMILIES, DRUGS AND ALCHOLISM

PRESENTED BY:

SARAH GREENE

PRESIDENT OF THE NATIONAL HEAD START ASSOCIATION

February 27, 1986

Good morning, Mr. Chairman, I am Sarah Greene, President of the National Head Start Association (NHSA). We appreciate the opportunity to testify today on the reauthorization of Head Start.

We welcome the strong support for Head Start and other key children's programs such as Child Nutrition, Child Abuse, School-Age Child Care and Resource and Referral programs from Senator Hawkins.

Head Start was a pioneer in the concept of providing young children and their families with an array of comprehensive services. Our program not only helps children begin school on an even footing, but also helps to strengthen their families as well. We have found that prevention in these key early years pay off.

Head Start works for children. Head Start children are less likely to be held back a grade or assigned to a special education class than similar children who did not attend Head Start. Children in Head Start obtain markedly higher levels of health care than children not in the program, have fewer absences from school and perform better on physical tests. In the program year 1983-84, 100 percent of the children enrolled ninety days or more completed medical screening, including all of the appropriate tests. Ninety-six percent of those identified as needing treatment received treatment. Ninety-five precent of the children were brought up-to-date in their immunizations.

Head Start also works for parents. Four out of five of Head Start children's parents are providing a volunteer service in the program. Thirty-one percent of the program's paid staff are

parents of current or former Head Start children.

We have also found that in order to be successful that we can not skimp the level of care and support that we offer to our families. This is a challenging and a perplexing time for all of us who have worked to build a strong and effective Head Start program. It is all but impossible to understand given the Gramm-Rudman approach to balancing the budget through automatic across-the-board reductions, how we will be able to continue to maintain the level of quality that has been the hallmark of Head Start. It is also difficult to grasp how we can accomodate such large cutbacks without serving even fewer children than we currently reach.

Because of limited funding, Head Start has never come anywhere near meeting the need. The program now reaches only 18 percent of those who are eligible: 452,000 low-income children are served but 2.5 million children need Head Start today. The gap between well-off children who are participating in an early childhood development program and low-income children who do not have access to this important experience is enormous.

More and more American families are enrolling their children in early childhood programs. Enrollment of three- and four-year-olds nearly doubled from 1970 to 1983. Fifty-three percent of three- to four-year-olds whose families have incomes at or above $25,000 attended a preschool program in 1982. However, poor children are not as likely to have this option. Less than 29 percent

of children whose families have incomes below $10,000 were enrolled in preschool in 1982.

Ironically, at the same time we face significant cutbacks and the real possibility of a weaker Head Start, the value of an early childhood development experience for low-income children is being recognized by policymakers across the country. This new attention makes it even more vital that we continue to invest the resources necessary to preserve a quality Head Start program. The role that a comprehensive early childhood development program such as Head Start can play in promoting a child's development has been the focus of a great deal of public attention much of it centered around the education reform movement. Policymakers ranging from the Research and Policy Committee of the Committee for Economic Development to the National Association of Elementary School Principals have recognized the importance of a public investment in early childhood development.

There has been a growing interest as a result in a number of states in early childhood development programs. The level of commitment and type of program vary widely. Last year, Maine made almost a $2 million investment in Head Start to enable every county to serve 20 percent of eligible children. Washington State has authorized but not yet provided funding for a law that would provide state funds for programs which meet important criteria similar to those which have led to Head Start's success. Illinois will spend $12.1 million and South Carolina $5 million for preschool programs.

However, we cannot depend on state efforts to fill the gap that exists between the children who need Head Start and those who are able to receive its vital services. In the South, many of our states have only recently funded kindergarten programs. Mississippi is just now appropriating state funds for kindergarten. Child care is also not faring so well. In 1986, Alabama plans to eliminate child care services for all children except for those -- approximately 350 children -- who have been placed in protective custody by the court system. In 1985, Virginia provided child care to 48 percent of the children that it served in 1981. Georgia and Louisiana are seriously considering reducing state support for child care. State funding for preschool is not a pressing agenda item in these states as well as many others.

State-funded early childhood development programs will never substitute for a strong federal Head Start program for another significant reason. Most are not able to reach low-income children and families in the same way that Head Start programs can. Many of the new initiatives do not offer the comprehensive services that are necessary to effectively helping low-income children and families. Rather, they focus narrowly on education only one of our program components.

The reasons for a comprehensive approach are grounded in commmon sense. Children who miss breakfast and have little to eat during the rest of the day will have a difficult time concentrating in school, and will generally fail to thrive. Children who are

sick and who do not receive regular health care will miss too many days of preschool, will be lethargic when they do attend, and will continue to suffer from these problems as they continue their school careers. Parents who are trapped in a cycle of poverty and deprivation can become partners in their children's learning experiences with special help. Finally communities which are involved in helping themselves and running their own programs can become stronger communities. The program's results prove that these components fit together well.

Head Start has always recognized the necessity of a comprehensive approach to early childhood development understanding that education, health, nutrition and social services as well as parent involvement were all vital if we were to reach low-income children and their families.

We reach families in so many ways. Programs provide parents with extensive, structured training in early childhood development. This not only assists them in their own parenting but acts as a ladder to permanent jobs in Head Start. Some programs go beyond adding components such as computer training, which ultimately gives parents on AFDC the skills to seek jobs outside of the Head Start sphere. It is difficult to capture on paper the scope of our commitment to families. It ranges from sponsoring shared meals, to counseling on a group or one-on-one basis, holding small group discussions on child abuse, economics, or meal planning, helping families to find housing, arranging transportation, and supporting families through special periods of crisis to countless other tasks in countless communities.

Our comprehensive approach is not the least costly route to providing services but if we skimp on any component, children and families will pay the price. We must keep Head Start intact. Legislation reauthorizing Head Start in 1984 addressed several areas that were important to the continued strength of a comprehensive Head Start program by:

- providing continued federal funding for the Child Development Associate Program. The CDA credential is a vital one for Head Start teachers to strive for as it helps to guarantee that they are skilled in a range of competencies essential to quality caregiving. Federal support is vital for CDA as it is extremely doubtful given the low salaries of providers that CDA could be operated solely on a fee-paying basis.

- guaranteeing a continued investment in training including CDA training. Research is clear that training is intimately-linked to the quality of child care. We must continue to invest in training as well as retraining for several reasons. Head Start staff is composed of a large percentage of parents, many of whom have not had the opportunity for formal child care training. The extraordinarily high turnover which characterizes Head Start as well as other child care programs also makes training a constant need. Head Start deliberately works to help parents move to higher paid jobs. As our parents leave Head Start with our assistance, new parents must be trained. Finally, experts agree that training is not a one-time only service and that staff benefit tremendously from in-service training. Without training, Head Start's quality will deteriorate. It is questionable what of value can remain if quality disappears. There is little financial assistance for training available from other sources. Separate training funds under the Title XX Social Services Block Grant were eliminated in 1981 and most states have cut back severely if not totally eliminated training for child care workers.

- strengthening the language surrounding Head Start's important performance standards to insure that programs will be held accountable to a comprehensive set of effective standards. These standards by addressing all four components help Head Start programs

in every community across this country provide the same high quality services to every child.

° allowing programs the opportunity to provide more than one year of Head Start service to children in their communities. We all realize that with such limited resources, it is key to be able to provide as many children as possible with the benefits of a Head Start experience. However, some children and families need help so desperately that one year is not enough to make a difference in their lives. Zigler and Kagan in "Child Development, Knowledge and Educational Practice,-Using What We Know" make the case for continuity of care as the first principle of child development. Children should remain in a continuous child development setting if at all possible. At a minimum, we must always have the option of reaching out to children and families who would slip through the cracks if we dropped them from Head Start after one year.

These changes helped to protect the continuing quality of Head Start services and guarantee that the program would be able to reach out with extra support to help our neediest families.

However, other issues remain that are difficult to address with diminishing resources. These concerns threaten both the quality of Head Start and its ability to serve additional children. Head Start salaries are very low. It is exceedingly difficult to recruit new staff. Recruitment is always with us because of the high turnover rate generated by these low wages. We cannot continually expect low-income women to be able to subsidize Head Start programs through their low wages. The rising cost of insurance has added a further financial burden on programs. Insurance has also added yet another factor to the painful trade-offs programs constantly struggle with - Do we serve another child, allow our workers to continue to sacrifice their own well-being by not raising salaries, pay the additional

costs of necessary insurance or expand the number of children in each classroom and diminish quality?

These dilemnas are obviously exacerbated by the budget reductions we are currently experiencing as well as the threat of futher cutbacks. It is difficult to envision what of Head Start will remain by 1991 if these automatic reductions continue. Head Start like other child care programs already operates on budgets with little elasticity. Since over 70-80 percent of our costs are wages, we do not have a large amount of fat to cut.

While to many, an across-the-board approach to budget balancing sounds sensible, it will have a devastating impact on the ability of Head Start to effectively reach the millions of children and families who are now living in poverty.

We must reauthorize Head Start, the Community Services Block Grant and the Low-Income Home Energy Assistance Program. The Community Services Block Grant is an important concern to Head Start since approximately two-thirds of our grantees are CAP agencies who provide valuable support services to the families we serve. These support services include making commodity foods available to supplement a limited food stamp diet, making it easier for low-income families who do not have access to transportation to apply at one site for life-line programs such as WIC, food stamps, and EPSDT, encouraging self sufficiency by providing job training and linking families to available jobs, and many others. The importance of coordinating services for our Head

Start parents cannot be minimized. Without this assistance, in urban areas they would be forced to take public transportation to multiple sites across town and in rural areas probably receive very few needed services. CAP agencies are an essential one-stop center that can help famlies with multiple needs.

It is not difficult to understand the importance of Low-Income Home Energy Assistance. Poor children living in homes with no heat during freezing winter months or in stifling and cramped rooms during the worst summer months are not going to be able to thrive or learn. Living under extraordinarily uncomfortable circumstances heightens tension in families already forced to cope each day with the pressures that come from being poor and continuously having to make Soloman-like choices between their basic needs.

We urge that reauthorization happen quickly so as not to be caught in the press of last minute business. It is time to express confidence in Head Start by approving a five-year reauthorization. It is also time to recognize the value of a Head Start experience for children and families and to provide for authorization levels that would allow for a $200 million increase during each of those years. If these funds were appropiated, we would still not even serve 50 percent cent of eligible children in 1991. We share members of Congress concern with the rising deficit. However, we can mortgage our nation's future by many choices. One such choice which clearly threatens the strength of our future workforce is to fail to provide the support that young children need in years that are critical to their development. We urge

you not only to move ahead to reauthorize Head Start but also to re-consider the Gramm-Rudman approach to the hard budget choices we must make as a nation.

Senator HAWKINS. Dr. Hutchison.

Dr. HUTCHISON. Senator Hawkins and Members of the Subcommittee on Children, Family, Drugs, and Alcoholism, it is an honor to be invited here today to testify in behalf of the American Psychological Association on the reauthorization of Head Start. I would like to commend your outstanding leadership in legislative efforts to provide quality services to children and families in this country.

I am Dr. Mary Ann Hutchison, the project director of the mental health demonstration and research discretionary grant entitled, "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention," funded by the U.S. Department of Health and Human Services and sponsored by California's largest Head Start delegate agency, serving 960 children and families.

For the record, I have submitted a copy of the executive summary on our grant and an extended copy of the following comments. I will discuss the mental health component within Head Start, summarizing research supporting the clear need for mental health services for this population, and I will also present some findings from the discretionary grant which I designed and directed that provided comprehensive mental health services to Head Start children and families. Finally, I will discuss the implications of this research for the broader Head Start Program.

Head Start has become the largest comprehensive child development program in the United States, serving over 400,000 children and families annually and has been a model of organizational innovation that has improved the lives of millions of young Americans and their families.

In recognition of Head Start's broad developmental approach, the varied components—education, health, social services, parent involvement, and the inclusion of handicapped services—were designed to serve the needs of a whole child.

Head Start has undergone a variety of changes over the years, but mental health, a part of the health component, has consistently been the least valued, least visible and least adequately funded of all the components of Head Start.

To give you an example of this, one Head Start agency serving approximately 800 children has a $62,000 handicapped budget, a $60,000 dental budget, and a $5,000 mental health budget.

For the most part, when a child has psychological problems, Head Start refers that child to outside agencies for assistance. However, research has consistently shown that our population will rarely use available community mental health services, for reasons that include the stigma attached to mental health, their distrust of the bureaucracy, and for the increasing number of ethnic minorities in this country, the lack of bilingual and culturally sensitive counselors.

The lack of mental health services provided to these children and families is troublesome in light of research findings that show that between 10 to 25 percent of Head Start children experience relatively severe developmental and psychological disturbances, which if left unchecked, have the potential for producing long-range dam-

aging effects, including psychopathology, delinquency, antisocial behavior, and alcohol and drug abuse.

Applying these figures to the Head Start population suggests that in any given year, in addition to the 400,000 children and families that would benefit from mental health prevention services, 40,000 to 100,000 of these children and families would stand to benefit from individualized mental health treatment services.

Dr. Cynthia Barnes, executive director of Manhattan Children's Psychiatric Center, which serves the borough of Manhattan as the State children's inpatient psychiatric hospital in New York City, states that 80 percent of the children in her hospital were previously enrolled in Head Start and only 10 percent of those children were detected while in Head Start.

In addition the known emphasis placed on assessing the cognitive effectiveness of Head Start, there has been a strong focus placed on the physical development of the child. For example, a 1984 study indicates that 90 percent of Head Start children received the needed medical screenings, and 86 percent had dental exams; and of these, 96 percent received the needed medical and dental treatment. In comparison, there is no national data available, or emphasis placed on Head Start mental health services.

Our project set out to determine whether the provision of three mental health interventions, staff training and consultation, parent education and involvement and in-house short-term psychotherapy, would lead to the reduction of psychological and behavioral problems in our population.

Our project viewed the family and child from a broad family-oriented perspective, rather than the more traditional child-centered approach. Parents were viewed and respected as the primary educators and socialization agents for their children.

Our goal was to work with parents and family members to enhance their functioning. We focused on existing strengths inherent in the family and on the nurturance of individual and family responsibility. The project was implemented for 3 years at the agency, and the findings represent the third year of the program.

The project provided three differing modes of service: prevention, early identification and treatment, and rehabilitation. All parents and staff received a detailed orientation to the program, at which time the stigma attached to mental health was openly addressed.

All 960 children in the program were observed in the first 3 months of the program and the children in need were referred to mental health for further evaluation and for in-house psychotherapeutic treatment, which included family, conjoint, individual and/or play therapy. Of the children, 199 and families were referred to the mental health component, representing 21 percent of our population.

Initially when we received referrals on the children, 75 percent of the original presenting problems focused solely on the child and 25 percent focused on the parents/family. After our assessment of the cases, a full 84 percent of the problems were attributable to problems in the family system. This dramatic shift supports our shift from a child-centered to a family centered program.

Problems which before assessment appeared to be solely child-oriented, such as aggressive behavior or withdrawn behavior, were

found to be related to parental/family problems, such as lack of parenting skills, marital, separation or divorce problems, or dysfunctional communication patterns.

Clearly, had we focused solely on the child, the effectiveness of our efforts would have been limited.

Of our families 61 percent followed treatment through to completion, which is a high percentage for treatment programs. Our success in treatment was based upon evaluations from 3 sources: parents, counselors and teachers. And our success in treatment ranged between 88 to 90 percent.

The comprehensive mental health services of this project cost $100 per child, only a fraction of the increasing costs of special education or the average of $50,000 per year or greater for institutionalization.

By neglecting the mental health needs of Head Start children and families, we jeopardize the possible gains made by the Head Start program.

With each Head Start family having an average of 5 people per household, Head Start has the potential to provide services to approximately 2 million people annually. A model such as the one that I have described, which provides comprehensive mental health services, has the potential over a generation to enhance the lives of 40 million people.

The Head Start Bureau has begun to recognize the importance of mental health by funding discretionary grants and by establishing a Mental Health Task Force. Still, I suggest that more can be done to help these families. I would urge the members of this Subcommittee to include language in the reauthorization of Head Start which would strengthen the commitment to the mental health component.

In addition to continuing research on mental health service delivery systems, Head Start needs to utilize the expertise and knowledge gained from demonstration and research projects, and also replicate their efforts.

The Head Start Bureau should also be encouraged to seek out linkages with other Federal agencies and programs, such as the ADAMHA services block grant, the Child and Adolescent Service System Program, and mental health training in order to utilize all available resources.

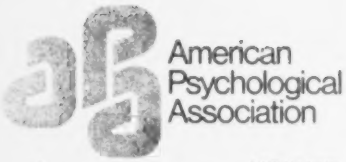
The targeting of mental health funds within Head Start, and an emphasis on prevention, early identification and rehabilitation is vital. More action is needed if mental health services are to become integrated into Head Start programs at local and national levels.

The time has come to actively prevent long-term damaging psychological and developmental disturbances. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

I thank you for this opportunity to testify in behalf of the American Psychological Association.

Senator HAWKINS. Thank you. You make a valuable contribution to this record.

[The prepared statement of Dr. Hutchison follows:]



PREPARED STATEMENT OF DR. MARY ANN HUTCHISON

Madam Chair and Members of the Subcommittee on Children, Family, Drugs, and Alcoholism, it is an honor to be invited here today to testify on behalf of the American Psychological Association on the reauthorization of Head Start, and I would like to take this opportunity to commend your outstanding leadership in legislative efforts to provide quality services to children and families in this country and, in particular, the Head Start program.

I am Dr. Mary Ann Hutchison, Project Director of the mental health demonstration and research discretionary grant entitled "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/ Intervention (MHP/IP), funded by the Office of Human Development Services and sponsored by the Latin American Civic Association (LACA) in Los Angeles, California's largest Head Start delegate agencies.

In the following remarks, I will discuss the mental health component within Head Start, summarizing research supporting the clear need for mental health services for this population. I will also present some findings from the discretionary grant which I designed and directed that provided comprehensive mental health services to Head Start children and families. Finally, I will discuss the implications of this research for the broader Head Start progam.

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Head Start and Mental Health

Since its inception in 1965, Head Start has become the largest comprehensive child development program in the United States, serving over 400,000 children and families annually. While some controversy surrounded the early evaluations of the program, over the past decade evaluations point to Head Start as a model of organizational innovation that has improved the lives of millions of young Americans and their families.

The Head Start program is composed of several different components, including health, education, nutrition, social services, parent involvement, and the inclusion (or "mainstreaming") of handicapped children. In recognition of Head Start's broad developmental approach, the varied components were designed to serve the needs of the whole child. Head Start has undergone a variety of changes over the years, but mental health, a part of the health component, has consistently been the least valued, least visible and least adequately funded of all the components. (e.g., one Head Start agency serving approximately 800 children has a $62,000 Handicap budget, a $60,000 Dental budget, and a $5,000 mental health budget). For the most part, when a child has psychological problems, that child is referred to outside agencies for assistance. However research has shown that this low income population will rarely use available community mental health services. The reasons for this include the stigmata attached to seeking mental health services, their distrust of the bureaucracy and, for the increasing number of ethnic minorities in this country, the lack of bilingual and culturally sensitive counselors. In addition, the highest priority in mental health programming and funding has consistently been for adults, severe pathology,

institutionalization, and aftercare facilities. The lowest priority has been for children, families, minorities, and prevention.

The dearth of mental health services provided to these children and their families is troublesome in light of recent research findings which indicate that between 10% and 25% of Head Start children experience relatively severe psychological and developmental disturbances which, left unchecked, have the potential for producing long range damaging effects, including psychopathology, delinquency and antisocial behavior, and alcohol and drug abuse. Applying these figures to the Head Start population suggests that, in any given year, in addition to the 400,000 children and families who would benefit from mental health prevention services, between 40,000 and 80,000 children in the program would stand to benefit from more intensive mental health treatment services. More evidence of the need for psychological services for children in Head Start comes from Dr. Cynthia Barnes, Executive Director of Manhattan Children's Psychiatric Center which services the borough of Manhattan as the state children's psychiatric hospital. She states that 80% of the children in the hospital had previously been enrolled in Head Start, but only 10% had been detected while in Head Start.

Within Head Start, there has been a strong emphasis placed on the educational, cognitive and physical development of the child. In contrast, far less effort has been expended on the contributions mental health professionals can make in improving the emotional lives of these children and their families. For example, a 1984 study indicates that 90% of Head Start children received medical screenings and, of these children, 96% received the

needed medical treatment; 86% had dental exams and, of these, 96% received the needed dental treatment. In comparison, there are no national data available on Head Start mental health services.

This is the foundation upon which our mental health discretionary grant, entitled "Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention (MHP/IP)", was developed. We set out to determine whether the provision of three mental health interventions, staff training and consultation, parent education and involvement, and in-house mental health treatment services (including short term psychotherapy), would lead to a reduction of psychological and behavioral problems in our population. It is important to note that our project viewed the child and family from a broad, family-oriented perspective rather than from the more traditional, individualistic child-oriented approach. As such, parents were viewed and respected as the primary educators and socialization agents for their children. Given this perspective, our goal was to work with parents and other family members to find ways to enhance their functioning in these roles, rather than supplant their activities. We felt that the most viable means for achieving the primary goal of Head Start - the promotion of social competence for children and families - would result from a focus on existing strengths inherent in the family and on the nurturance of individual and family responsibility. The project stressed a team approach to treatment, where parents, counselors, and teachers joined together to serve the needs of the child and the family. The project was implemented for 3 years in the largest Head Start agency in California, serving 960 children and families. The project was staffed with a licensed mental health specialist (myself) and 5 full time counselors. Our findings represent the third year of the program.

The project provided three differing modes of service: prevention, early identification and treatment, and rehabilitation. Our preventive services were designed to enhance parent-child-teacher interactions both in the classroom and in the home. All parents and staff received a detailed orientation to the program at which time the stigmata attached to mental health was openly addressed. Mental health was presented in a positive, simple, down to earth, and culturally meaningful fashion. Parents were encouraged to attend parent education sessions, and were supported as the primary educators of their children. The staff received comprehensive training and consultation on positive mental health in the classroom and on serving the needs of the individual children in the classroom.

With respect to the second service modality, early identification and treatment, all children were observed by the counseling staff in the first 3 months of the program, and the children in need were referred to mental health for treatment or to the appropriate component. When a child was referred for mental health services, a classroom observation was made, followed by a parent-teacher conference with the mental health counselor to discuss the problem and explain the mental health services. This was followed by a session with the parent(s) and later by a session with the entire family. A recommendation for treatment was then discussed and agreed upon in collaboration with the parent(s). Treatment might include one or more of the following: family, conjoint, individual and/or play therapy. Eight weeks after a case was closed, a review was conducted to evaluate the success of treatment. If problems had arisen, the family could resume treatment. For children in need of long term intervention, services were coordinated with the handicap component and referrals were made to appropriate agencies for continued services.

Let us briefly discuss some of the major findings. Of the 960 children and families in the program, 199 (21%) were referred to mental health. When the referrals were initially made, 75% of the original presenting problems focused solely on the child while 25% focused on the parents/family. After our assessment of the cases, a full 84% of the problems were attributable to problems in the family system. This dramatic change supports our shift from a child centered program to a family centered program. Problems which, before our assessment, appeared to be solely child-oriented (e.g., aggressive behavior, separation anxiety, withdrawn behaviors, speech problems and age-inappropriate behavior, etc.) were found to be related to parental/family problems (e.g., lack of parenting skills, a parent's own unresolved problems, dysfunctional communication patterns, and marital, separation, and divorce problems, etc.). Clearly, had we focused solely on the child, the effectiveness of our efforts would have been limited.

Of the cases referred to mental health, 61% followed treatment to completion, which is quite high for treatment programs. Our success of treatment was based upon evaluations from 3 sources - parents, teachers and counselors. The success in treatment ranged between 88% and 90%.

The comprehensive mental health services of this project cost $100 per child, only a fraction of the increasing costs of special education or the average of $50,000 per year or greater for institutionalization.

Summary and Recommendations

Historically, Head Start has placed far less emphasis on the mental health component of the program than on other components. By neglecting the mental health needs of those children and families who would benefit from professional assistance, we jeapordize the gains made by the Head Start program.

With each Head Start family having an average of 5 people per household, Head Start has the potential to provide services to approximately 2 million people annually. A model such as the one I have described, which provides comprehensive mental health services in the areas of prevention, early identification and rehabilitation, has the potential, over a generation, to enhance the lives of 40 million people.

The Head Start Bureau has begun to recognize the importance of mental health by funding research and demonstration programs from their discretionary fund and by establishing a Mental Health Task Force. Still, I suggest that more can be done to help these families. I would urge the members of this Subcommittee to include language in the reauthorization of Head Start which would strengthen the committment to this component. In addition to continuing research on mental health service delivery systems, Head Start needs to utilize the expertise and knowledge gained from demonstration and research projects, and also replicate their successful efforts. The Head Start Bureau should encourage local Head Start agencies to bolster the mental health component of their health services. Finally, the Head Start Bureau should be encouraged to seek out linkages with other federal agencies and programs, such

as the ADAMHA services block grant, the Child and Adolescent Service System Program (CASSP), and mental health training in order to utilize all available resources.

A commitment to mental health is critical in accomplishing the primary goal of Head Start - the promotion of social competence of children and families. The targeting of mental health funds within Head Start, and an emphasis on prevention, early identification and rehabilitation is vital. More action is needed if mental health services are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbance through comprehensive mental health services. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

Thank you for the opportunity to testify on behalf of the American Psychological Association on the reauthorization of Head Start. If I can be of any further help in your deliberations, please feel free to call on me.

Senator HAWKINS. Dr. Smith?

Dr. SMITH. Thank you, Senator Hawkins.

I am here today representing the National Association for the Education of Young Children. On behalf of our 50,000 members who are early childhood professionals working with young children and their families, I want to thank this Committee for your understanding and support of all types of efforts to improve the quality of the programs experienced by young children. Thank you for your support not only in Head Start, but in all types of group programs, including child care and family day-care settings

The goal of the National Association for the Education of Young Children, throughout our 60-year history, has been that whenever young children are in group programs, we must assure that the program will enhance their development—not harm it. We know that the single most important determinant of the quality of these group programs for young children is qualified staff-adults who have special training for the skills required amd can demonstrate these skills in actual practice.

The critical importance of qualified staff was understood both by government and professional organization representatives when the Child Development Associate [CDA] Project was launched in the early 1970's. I had the fortune of representing NAEYC at that time. We worked in task groups and collaborated with government representatives and professional representatives to define the competencies of people working with young children. We then designed an innovative way of providing a credential—innovative in the sense that it is competency-based so that the credential comes after a person demonstrates that he can actually perform these competencies.

In 1975, I was again able to represent NAEYC when we awarded the first CDA credentials to the first 10 Head Start teachers in 10 regions who had completed the program. And at that time, we dreamed of a future when the majority of the children in group programs in this Nation could be assured of qualified, competent teachers; 11 years later, it is exciting to see that much progress has been made, but we must acknowledge how much work is left. Today, we have over 17,000 individuals who have earned the CDA credential, bringing high-quality care to more than one-half million young children.

Table 2 in the prepared testimony presents a State-by-State listing of the numbers of CDA's in each State.

But the need for more credentialed staff remains great, for according to Head Start's own statistics, only 30 percent of Head Start teachers have either a CDA credential or a degree in early childhood education. So much is left to be done.

The testimony prepared for the record summarizes all the ways in which training and credentialing have contributed significantly to the professionalization of staff working in Head Start and in other forms of group programs. They learn to do their jobs better; they gain confidence; they gain professional esteem; and they become connected to people and programs who can help them continue their professional growth as they work with children and their families.

The written testimony also documents the growing acceptance of the CDA credential as a standard for competency by agencies who regulate requirements for child care providers.

The Administration for Children, Youth, and Families [ACYF] has declared it a national goal to have by 1990 at least one qualified adult who has either a degree in early childhood education or a CDA credential in every Head Start classroom.

In growing numbers, private child-care centers are providing training funds to pay CDA credentialing fees for their employees, noting the improvement in their performance.

The U.S. Army Child Development Services has initiated plans to use the Child Development Associate Program to train and credential their child-care staff all over the United States and abroad.

Also significant is the fact that over 60 percent of the States in the United States have recognized the value of the CDA credential by incorporating it into their State standards. That information is presented in table 1

The testimony elaborates on the important distinction between the power of the CDA Program to set standards and the power of the States to regulate standards. The CDA credential as a national standard is set by the profession and is entirely voluntary. Licensing requirements for child-care centers include standards for teacher qualifications. The licensing requirements are set by individual States, are regulatory and as such are mandatory.

Thus, the separate powers of these two systems—State licensing standards and CDA competencies—work in concert to maintain a responsiveness to our best knowledge and expertise about quality child care. They also remain responsive to diverse, local conditions and local needs.

Although the accomplishments of the CDA credentialing program are great, ACYF has observed a need to strengthen the future stability of this program and they have sought the assistance of NAEYC. They came to NAEYC in the spring of 1985 and asked our association to enter into a cooperative agreement with them to find a way to assure the stable future for CDA.

On September 1, 1985, NAEYC formed a separate subsidiary organization to administer the Child Development Associate Program. To do this, we formed the Council for Early Childhood Professional Recognition, and the remainder of my remarks will summarize the three recurring issues that the council will be studying.

I should clarify that the council is maintaining the Child Development Associate Program, continuing its operation, and taking on the study of these three major issues in the next 3 years.

The first major issue is the link between the CDA Program and the traditional college and university system of training early childhood personnel. The CDA credential was never meant to be a substitute for college-based training. Instead it was intended to focus on the outcome of training, rather than the process of training. Although the outcome of training has remained the focus of the program over its 11-year history, a great many different kinds of informal connections to colleges have evolved. In many cases, colleges have absolutely changed their curriculums to be in concert with the child development associate competencies. They also have

provided courses which prepare students for the CDA assessment process.

The flip side occurs when a person goes through the child development associate process without formalized college training. As a result of getting the CDA credential and demonstrating competence in practice, the person becomes assured that they too could successfully complete college work and begin working toward their college degree.

The question that has been repeatedly raised is: "What is the relation between traditional training institutions and the CDA system?" In a systematic way, we are going to examine the question and collaborate with ACYF to try to find a way to foster uniformity in the quality of CDA training. This will enable us to facilitate the career development of individuals who really want college degrees in early childhood education.

The second issue we will be studying is how to gain greater access to training and credentialing for the child-care community. Senator Hawkins, you said in your opening remarks how much you have noted and value what Head Start parents have been able to achieve through training opportunities in the Head Start Program. Because of your interest in this field, you are aware that in family day care and child-care programs; there are individuals who are isolated and not tied into any formalized training opportunities.

The child development associate credential now offers a program for family day-care providers. CDA will be looking at a way to link these family day-care providers into a network of training resources so that they too can achieve more skills and increased competency in working with children.

The third issue that we will be studying is the cost question, both the issue of affordability to the child-care-worker and the cost efficiency of the national program.

Although, at present, the cost of the credential as a professional certification is very reasonable, that cost is perceived as a burden by the individual child-care provider.

We will examine whether the burden of that cost can be lessened, perhaps by convincing other individuals or institutions who benefit from the existence of high-quality child care to share the investment. We will be looking at the willingness of employers to help share that cost, and the corporate, and business interests in helping serve and improve child care in this country.

We also are not just concerning ourselves with how the project can live from year to year on Federal subsidies. Because of our collaboration with ACYF to establish a permanent home for CDA, we have a continuing responsibility to ensure the fiscal viability of the program. Thus, during the 3-year period, we will be studying how we can make an organized and realistic economic structure for the future of the CDA Program. We will be examining all kinds of cost factors while we are structuring ways to increase the efficiency of the operation. We cannot predict the outcome of this study, but we do promise a thorough review of the enormous economic complexity that surrounds various child-care programss and a wellthought-through, economically feasible plan should the program need continued Federal support.

While we have just launched these studies, we are already very pleased with the responsiveness of Head Start personnel, Head Start parents, and the early childhood community in helping us gather information and look toward the future.

We are pleased at the progress we have been able to make, but we know that much work lies ahead. We urge your support for the reauthorization of the Head Start bill which supports staff training and credentialing.

When children are placed in group care, programs must have qualified staff to protect the children's welfare and enhance their development.

We are eager to continue the next 3 years of our work to ensure quality care for our Nation's children. They deserve no less.

Thank you.

Senator HAWKINS. Thank you.

[The prepared statement of Dr. Smith follows:]

Council for Early Childhood Professional Recognition
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CDA National Credentialing Program

Testimony

before the

Subcommittee on Children, Family,
Drugs and Alcoholism

U. S. Senate

February 27, 1986

Marilyn M. Smith

Executive Director
National Association for the Education of Young Children

Ms. Chairman, thank you for the invitation to appear on behalf of the CDA National Credentialing Program. My name is Marilyn Smith; I am the Executive Director of the National Association for the Education of Young Children (NAEYC). I am here to talk about the Child Development Associate National Credentialing Program which NAEYC supports.

In the Spring of 1985, NAEYC entered into a cooperative agreement with the Administration for Children, Youth, and Families (ACYF) to explore ways to assure a stable future for the CDA National Credentialing Program. In the process of deliberating with ACYF on ways to strengthen and ensure the future stability of the program, NAEYC formed a subsidiary organization: the Council for Early Childhood Professional Recognition, which now administers the CDA National Credentialing Program. The fact that NAEYC has assumed responsibility for the CDA program through the formation of the Council brings the CDA program under the auspices of a major organization which represents the early childhood profession, and it means increased support for the program by the profession: NAEYC has a long and distinguished history; it is a 60-year-old organization whose purpose is to assure that children receive high quality care and education during their earliest years. Our membership of 50,000 includes professionals who work in all facets of early education and care--teachers, researchers, advocates, and parents.

We would like to thank the members of this committee who have supported our efforts to improve the quality of child care through the training and credentialing of child care workers. Thank you for your continued support for this worthy program.

I would like for my remarks today to serve as a status report about the CDA credentialing program, first explaining its accomplishments. After that I will address how the Council intends to approach some recurring unresolved issues of CDA certification, showing why it deserves the continued support of the federal government at this time.

This program is vitally necessary to high quality care of the nation's children. Now in its 11th year, the CDA program provides specialized training to Head Start and other early childhood staff, culminating in a competency-based assessment of the candidate's actual work with children as observed in the classroom. Today, over 17,000 individuals have earned the CDA credential, bringing high quality care to more than one-half million young children.

The benefits of the training and the credential to program participants in Head Start as well as the child care community can be summed up in one statement: the CDA credentialing system contributes to the professionalism of the child care staff. For one thing, the staff members learn how to do their job better, more professionally. In a 1983 nationwide survey of CDAs, 93% of the respondents said that becoming a CDA improved their work with young children. As a woman from Alabama wrote,

> "When I first began working, it was my love for children along with bits of knowledge gathered from experience that helped me keep my class moving. The CDA has changed all of that. My activities are no longer hit and miss or guesswork. I have learned how to plan activities to meet individual needs of my children and choose materials to agree with these activities.... It is important to love children, but love and competence together will make a big difference."

The second way in which the CDA system contributes to professionalism of the caregivers is that it increases their professional esteem and confidence by reinforcing the idea that they are professionals, not just baby sitters. As a CDA from the state of Washington wrote,

> "What is more important than our children? Quality care and guidance in the preschool years have been shown to be important for success in later life. The roots of responsibility, independence, self-reliance, and creativity all should be nurtured early. Our society is just beginning to realize this. Too often, childcare means daycare means babysitting means something anyone can do."

The third way in which the system contributes to the professionalism of the child care staff is that it links the caregiver to a network of professionals in her field and motivates her to seek access to current information that helps her continue to improve her skills. Referring again to the 1983 survey of CDAs, 93% confirmed their heightened commitment to being a part of the professional early childhood community. As one CDA reported, "The effort and work involved and the end results proved to me that I am somebody. I can be successful and continue to grow."

CDAs, like every group of professional workers in this nation, take pride in their skills and strive to become even more proficient, and as a consequence their presence contributes to an increased number of safe and developmentally sound settings for young children in child care.

Another dimension of the CDA program's vital contribution to the welfare of the nation's children is its growing acceptance as a standard for competency by agencies and

institutions who regulate requirements for child care providers. ACYF has declared it a national goal to have by 1990 at least one qualified adult, who has either a degree in early childhood education or a CDA credential, in every Head Start classroom, plus have a qualified group of Home Visitors. Private day care centers are beginning in growing numbers to provide training funds and pay CDA credentialing fees for their employees. The U.S. Army Child Development Services has initiated plans to use the CDA program to train and credential its child care staff all over the United States and abroad. And more and more, the CDA credential is being recommended as a qualification of early childhood personnel by associations, state committees and commissions, and other child welfare groups.

Significant as well is the fact that over 60% of the states in the United States have recognized the value of the credential by incorporating it into their state standards. [Table 1 shows the names of states incorporating CDA into their state standards.]

It is important to highlight here the distinction between the power of the CDA program to set standards and the power of states to regulate standards. The CDA credential as a national standard is set by the profession and as such is entirely voluntary. Licensing requirements for child care centers include standards for teacher qualifications. These requirements are set by individual states, are regulatory and as such are mandatory. Yet while state licensing standards and CDA competencies remain separate and distinct from one another, serving separate purposes and being responsive to separate

constituencies, they work in concert. The standards which the CDA assessment system represents have been used as advisory and guidance tools by states in determining requirements for quality child care providers, and in fact have been especially valuable for states involved in reviewing and improving their state standards. The variety of ways states have found them valuable reflect great diversity. For example, in some states, the CDA credential is the sole staff requirement for center licensing. In others, however, CDA is only one option among many, including state-approved training or an associate's or bachelor's degree in early childhood. As a result, then, of the separate powers of the two systems, child care standards in this country can maintain both a responsiveness to our best general knowledge and expertise about quality child care and a responsiveness to diverse local conditions and local needs.

The accomplishments of the CDA program are many, as evidenced by the growth of the program since it began awarding credentials in 1975. By its fifth year, the program was awarding over 2,000 credentials yearly. Even after the difficult years of 1979-1980 when the program lost its financial support, it continued to award over 1,000 credentials yearly. And it anticipates reaching 3,000 credentials awarded per year by 1987. This country now has over 17,000 CDAs from 50 states, two territories, and the District of Columbia. [Table 2 shows the number of CDAs in each state.]

With these accomplishments in mind, the Council for Early Childhood Professional Recognition, which assumed administration of the CDA program on September 1, 1985, is

planning for the future. Our efforts will be continuing to strengthen the efficiency of the training and assessment system, to increase the credibility of the CDA credential, and to facilitate access for more child care providers across the country. In doing so, we will address several recurring and unresolved issues. These issues are (1) the link between the CDA program and college and university training, (2) greater access for the day care community, and (3) cost efficiency of the assessment system.

First is the link between the CDA program and the traditional college and university system of training early childhood personnel. The CDA credential was never meant to be a substitute for college-based training, but instead was intended to focus on the outcome of training rather than the process of training. Although the outcome of training has remained the focus of the program over its 11-year history, a great many different kinds of informal connections to colleges have evolved. We know, for instance, that some colleges and universities, as part of their regular degree programs in child development and early childhood education, provide courses which prepare students for the CDA assessment process. We also know that some CDAs become involved in college and university programs as a result of getting their CDA credential. One CDA from Utah, for example, reported that the CDA credentialing process gave her the confidence to go back to school. In another example, a provider in a Head Start program decided during CDA training to continue her formal education and later sought a degree.

One question that has been repeatedly raised is what is the relation between traditional training institutions and the CDA system? In a systematic way the Council will examine this question over the next three years and collaborate with ACYF to detail and try out a plan to foster uniformity in the quality of CDA training and to facilitate the career development of individuals who really want college degrees in early childhood education. We think we can develop viable connections between colleges and the CDA program.

The second issue the Council will address is greater access for the day care community. 70% of children in child care in this country are in family day care. Until the fall of 1985, the CDA credential was not available to family day care providers, but now that it is, the project will systematically explore linking those family day care providers into a network of training resources through the CDA credentialing effort. We think the benefits to the family day care providers will be great, just as they have been for Head Start. As family day care providers acquire more skills, their job of working with children will become easier. Gaining skills and a credential of competency would contribute to their professional esteem and act as motivation for continued professional growth and development. We think the outcome could be increased stability in the day care community, and thus continuity for children in child care. Research is only beginning to tell us what the effects of multiple child care givers is for young children, but we do know that stability and consistency in child care settings contribute to their sound developmental progress.

The third unresolved issue that the Council will address is the cost question, both the issue of affordability to the child care worker and the cost efficiency of the national program. Although at present the cost of the credential as a professional certification is very reasonable, nonetheless that cost is perceived as a burden by the individual child care provider. We will examine whether the burden of that cost can be lessened, perhaps by convincing other individuals or institutions who benefit from the existence of high quality child care to share the investment in training and credentialing staff. We have seen a growing willingness on the part of employers to share the cost of credentialing because of the benefits they realize with increased productivity of employees. Also, we have seen corporate and business interest in investing in the provision of child care training because businesses see corporate benefits. What we will be seeking is ways to nurture these trends by increasing the credibility of this credential in the eyes of the general public and of the child care consumers, whose investments in it might contribute to reducing the cost burden to the individual.

Further, we are not just concerning ourselves with how we can live from year to year on federal subsidies. But rather, NAEYC's collaboration with ACYF to establish a permanent home for CDA brings with it continuing responsibility to ensure the fiscal viability of the program. This means that three years of continued federal funding will make a major contribution to our ability to put into place an organized, coherent and realistic economic structure for the future. Our goal is to

achieve that for the program by examining cost factors, while we are structuring ways to increase efficiency of the operation. We are not predicting self-sufficiency from federal funds, nor are we predicting continued reliance on them. We recognize that legislative efforts such as the CDA Scholarship Bill may remain for many years to come an important adjunct to the CDA program effort. We do promise, however, a thorough review of the enormous economic complexity that surrounds various child care providers and a well-thought-through, economically feasible plan should the program need continued federal support.

These are the issues that the Council has begun to resolve. Our work will be assisted by panels of experts, which have already been named, from across the country to study and review the CDA system. We have put into place a communication network through such channels as Head Start and professional associations to alert the early childhood community that we want to hear their experiences and their opinions. We are already receiving comments from them. Articles about the study and review have appeared in professional publications and day care newsletters, such as National Association of Early Childhood Specialists in State Departments of Education Update, and National Head Start Association News.

We are pleased at the progress we have been able to make, but we know that much work lies ahead. We urge your support for the reauthorization of the Head Start bill which supports staff training and credentialing. Whenever children are placed in group care, programs must have qualified staff to protect

the children's welfare and enhance their development. The need for more credentialed staff remains great, for, according to Head Start's own statistics, only 30% of head teachers have either a CDA or a degree in early childhood education. We are eager to continue the next three years of our work to ensure quality care for our nation's children; they deserve no less.

TABLE 1. STATES INCORPORATING CDA IN STATE STANDARDS

As of February 1986, the following 32 states (plus the District of Columbia) have incorporated the CDA Credential into their state licensing regulations as an option for child care staff qualifications.

Arizona
Arkansas
Colorado
District of Columbia
Georgia
Hawaii
Illinois
Iowa
Kansas
Maryland
Michigan
Minnesota
Montana
Nebraska
Nevada
New Jersey
New Mexico
New York (excluding New York City)
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Texas
Utah
Virginia
Washington
Wisconsin
West Virginia

In addition to the above, the California Commission on Teacher Credentialing voted to incorporate CDA into their Limited Regular Children's Center Instructional Permit Requirements.

TABLE 2. NUMBER OF CDAs BY STATE
February 1, 1986

STATE	TOTAL
Alabama	387
Alaska	71
Arizona	588
Arkansas	449
California	881
Colorado	349
Connecticut	127
Delaware	43
District of Columbia	35
Florida	365
Georgia	408
Hawaii	213
Idaho	101
Illinois	802
Indiana	277
Iowa	259
Kansas	207
Kentucky	237
Louisiana	629
Maine	73
Maryland	165
Massachusetts	166
Michigan	735
Minnesota	450
Mississippi	838
Missouri	590
Montana	171
Nebraska	148
Nevada	125
New Hampshire	28
New Jersey	195
New Mexico	347
New York	502
North Carolina	472
North Dakota	56
Ohio	770
Oklahoma	389
Oregon	126
Pennsylvania	532
Puerto Rico	169
Rhode Island	52
South Carolina	383
South Dakota	70
Tennessee	307
Texas	1,378
Utah	130
Vermont	31
Virgin Islands	23
Virginia	243
Washington	487
West Virginia	130
Wisconsin	309
Wyoming	86
TOTAL	17,103

Senator HAWKINS. We have been joined by Senator Quayle.

Senator QUAYLE. Thank you very much, Madam Chairman.

First, I want to pay my high regards and compliments to you for having this hearing and once again leading the charge in Head Start and other programs that I know are very important to you, and high on your agenda, and high on all of our agendas.

I do have a statement that I would like to insert in the record, without objection.

Senator HAWKINS. Without objection.

Senator QUAYLE. I have a couple of questions I would like to ask.

Senator HAWKINS. Surely

Senator QUAYLE. I guess one of the things I would like to get the panel to think about and offer a statement on how we could get as much coordination as possible with Head Start Programs, and other programs, particularly, I am thinking at the Federal level, of how we could get better coordination.

I know each individual city has its own idea of coordination. We coordinate with a lot of other entities. Particularly volunteers. I think that one of the programs that has been mentioned is coordination with the Foster Grandparents Program. I just wonder if there are some things that we might want to consider at the Federal level to encourage coordination of other programs with Head Start that would help out the delivery of services at the local level.

I am just thinking of the Older Americans Act, and all the RSVP Programs; if we would encourage this kind of coordination, do you think that this would be helpful, and if so, who should we encourage coordination with you from the Federal level? Maybe we should mandate coordination—but we want to try to get more coordination amongst our various programs that help preschool children.

Any thoughts on that, Ms. Greene?

Ms. GREENE. Yes, I do. First of all, I think that is a very excellent idea, and I do want to say that much of that is going on. There is room for improvement. Within the last couple of years there has been a lot more emphasis on interagency agreements and they have been established, such as with the Red Cross, at a national level. There has been work done on trying to get an agreement with the Department of Labor as it relates to JPA, and whether or not Head Start parents are qualified to go through the CDA training and be paid for it through that kind of program.

So there are lots of areas that are going on, but it certainly needs to be done more so. One of the areas that we have talked about is in the area with HUD. Facilities are a large problem with Head Start Programs. The cost of renovating, leasing, and then having to move, pay costs again to renovate, is a tremendous problem in Head Start Programs throughout the country. And many Head Starts locally and Statewide have been able to take advantage of some of the HUD Programs—Community Development Block Grant moneys, for instance—and build centers, permanent status, so that you will not have to worry about moving from year to year and, as I said, paying high lease costs. If something from a national level from that standpoint could come down so that programs like Head Start could have some kind of priority in terms of dealing with the Community Development Block Grant money. But there

are many, many areas that we still need to do more of that. But it is happening, and we want to see more of it.

Senator QUAYLE. Do you think it would be helpful if we would specify particular things that ought to be coordinated with Head Start?

Ms. GREENE. Yes, and we could submit to you later written comments on that. I think it helps local programs and State programs when the national sends down something that already says we should get together and work on these particular areas. It is easier for those programs to make entry into those different local and State agencies.

Senator QUAYLE. Madam Chairman, I think that might be worthwhile to explore how we might be able to get better coordination.

Senator HAWKINS. Surely. If you have several ideas, we look forward to working with you on that.

Senator QUAYLE. Ms. Greene, you mentioned the JTPA, which is one of my favorite programs, since we wrote the legislation with a lot of help from Senator Hawkins and others. But how is the coordination going with JTPA, and how would you like to see it increase?

Ms. GREENE. I think right now it is going well and could go better. I serve on a local PIC Board in my community, and most of the Head Start Programs and Community Action certainly utilize the services of JEPA in bringing people in to train and then employ.

I think that the percentage of people who have been on permanent-status job in our programs is extremely high, I know in our area in the State of Florida, and I think throughout the country. There are Head Start Programs, I know, in New Jersey who, all of their CDA people, parents and staff, are paid for through the JEPA Training Program. And this kind of thing is going on throughout the country, and I think it really adds to the coordination that is needed to extend the training that Head Start does for parents and helping them to have a job so that they can become self-sufficient.

Senator QUAYLE. So this would be the training of the parents of the kids——

Ms. GREENE. Two parts, yes, the training and also employment.

Senator QUAYLE. And employment, of course. The training, as you pointed out, leads in many cases to the employment. Nationwide, the adults that we train, we are placing 75 percent in employment, which is a tremendous turnaround of where we were before, and of the kids, the young people, we are placing something like 60, 65 percent.

Ms. GREENE. I have been especially pleased in the last 2 years with the screening process, the monitoring and assistance that the local JEPA offices have used with the clients this year. There has been more placement, permanent placement, of employees.

I have been involved, too, since NYC and CETA, and now JEPA, and I think the past few years have certainly seen a turnaround in terms of employment for people that need jobs.

Senator QUAYLE. Yes, would you like to comment?

Dr. PHILLIPS. Yes. I would like to add that the national CDA Credentialing Program is assisting in coordinating information about the cooperative agreement between the Department of Labor and

Health and Human Services, simply through the communication network that we have through CDA training.

People in various parts of the country do not know how to begin getting the information about JTPA and getting the mechanism going such that they can take advantage of those training opportunities. We have had many calls. In the newsletters and the information that we send out about CDA, we have encouraged people to contact us for information about that project, as well as send us the stories about how they have achieved a successful relationship through these PIC councils. And we are beginning to network people who have done it with people who are attempting to do it, so that the program can be fully utilized locally.

Ms. GREENE. I might add there will be a special panel session during our national conference in April on Head Start and JTPA and what is going on in the country and as Ann has said, how to further utilize the service for those who are not aware.

Senator QUAYLE. We look forward to your findings.

Ms. GREENE. Thank you.

Senator HAWKINS. To follow up on that, Senator, in oversight hearings in Florida, we discovered that the local PIC's did not understand that they could ask for a waiver to provide for child care. That extra step was not being utilized, and so a lot of women could not be trained because they did not have the child care, and they thought, "I would not qualify; I cannot get approved." And we found out that all who had asked for waivers were approved. I do not believe that this extra step was our intent. That was something that got written up in the regs, and it is our intention to change that this time.

Also, with training, are the rural areas getting the amount of attention given those in the urban areas? We had quite a conversation when we were in Florida: training is as vital in the rural areas as in the metropolitan areas. I do not believe we use the universities enough in CDA. I mean, we may use 4-year universities in my State. But there are 2-year universities all across Florida. The Baltimore Program nearby is wonderful, and it seems to me that it is a 2-year program. We need better networking, using the 2-year university as your base, because they are everywhere. And this is a vital step.

I know private industry is using the CDA to certify their child care people that are going to go back into the company and take care of the children. Child care is the No. 1 perc today requested by the employees, child care. So to get the CDA certification, they are using our CDA Program. But they do not go into Head Start; they go over to the child care, which is not an education program.

While I am talking about child care, I have a big problem, you know, with block grants when it comes to child care because I think that we are seeing evidence where several States have decided to do away with child care. I have already been working on getting more money targeted.

The money is there, and the intent was directed in the right place, but I think oversight is what we need to do in a lot of these programs to see that they are tuned up to the eighties.

Dr. PHILLIPS. Well, as we pointed out in our statement, historically from the beginning the program really did concentrate primarily

on getting some consensus from the profession about what constituted competency for child care providers; also, getting a mechanism in place to credential individuals, and spreading information about the CDA credential, its availability, primarily to center based Head Start teachers. At this point, NAEYC and the council have taken on a much broader perspective in terms of how this credential can, in fact, become more credible and accessible to a wider population while the mechanics of managing such a system have not necessarily had a history of stability, we have had a solid base to build upon. And we are now in a position to be able to look at expanding the links between the public sector and the private sector and interagency agreements with the Department of Labor for instance. We mentioned the Army initiative, which we think is going to be very important. I found that simply the existence of a set of standards that have been in fact endorsed by the profession has been tremendously useful to individuals, organizations, agencies, and Government bureaus who are looking to improve their child care delivery. They do not have to reinvent the wheel. They can take a look at the CDA definitions, the skill areas and indicators that are already encompassed in this project and evaluate them in terms of what their local needs are. And many have really accepted these as relevant to their own particular situations.

Senator HAWKINS. I think one of the most inspirational paybacks is to visit a Head Start Program where you see young mothers who have had no credentialing whatsoever prior to becoming a mother, working with the children, taking this training, working in Head Start—and I would say 80 percent of them are pregnant and expecting their second or third child. The payback in the future is going to be fantastic, because if they were not in this program, they would be having no training at all and still be having many children. And we are giving them such a hand up, not only for employment, but for training and educating their own children. I think the future payoff is fantastic here, in the community programs.

I am interested in the mental health statistics that you gave, Dr. Hutchison. Are there enough people trained to work with these children?

Dr HUTCHISON. In the existing community mental health system, nationally, in the areas of programming and in funding, the emphasis is placed on adults, severe pathology, institutionalization, and aftercare facilities. Consistently, the lowest priority in the areas of programming and funding has been for children, families, minorities, and prevention. In addition, a preshool, high-risk population is a very specialized group for which few clinicians are trained to work with. That is the reality of the situation.

To give you an example, a community mental health program which serves the area where the agency is located; has two full-time bilingual counseling staff. There is usually a waiting list for 3 to 4 months, and when they are able to take people on, they are only able to place them in group therapy, so individualized needs are not able to be met.

The focus of what we were looking at in our program and wanting to replicate is to provide in-house mental health services in Head Start, because of the severe needs present with our popula-

tion. I am not suggesting that we reinvent the wheel, but the reality is that the existing mental health system presently is not able to meet the needs of these children and families. We in Head Start have a responsibility to hire and train the mental health staff to serve the needs of these children and families if we are truly committed to preventing long-range damaging effects.

Senator HAWKINS. Senator Quayle.

Senator QUAYLE. If I could ask Dr. Hutchison one question, I was surprised at the statement that you made in your testimony where you said 80 percent of children in the Manhattan Children's Psychiatric Center had previously been enrolled in the Head Start Program.

Why? Is this nationwide?

Dr. HUTCHISON. Senator, what I was giving was the statistic of that children's psychiatric facility. I was also surprised when I heard that statistic.

Senator QUAYLE. I mean, 80 percent of these people were in Head Start before? I would hope—is this an aberration, or is this a statistical——

Dr. HUTCHISON. This is a psychiatric facility that serves——

Senator QUAYLE. I understand, but 80 percent of the kids that they serve came from the Head Start Program. Isn't that a surprising statistic, or not? It is surprising to me.

Dr. HUTCHISON. The reality, is that State facilities serve a low-income, high-risk population. A large percentage of low-income, high-risk children attend Head Start. It is not that all of our Head Start children are going into State institutions——

Senator QUAYLE. I understand that. I certainly understand that. But 80 percent—in other words, you do not think this is an aberration. You think this is probably a norm?

Ms. GREENE. No, no.

Senator QUAYLE. Ms. Greene disagrees.

Dr. HUTCHISON. Having been involved with Head Start for several years, I have seen the reality of the severity of need of the children in the program, and when I am consistently seeing over a 3-year period 21, 22, and 23 percent of children and families having severe problems being referred to the mental health component, then I see the reality of the situation within Head Start.

We are serving a high-risk population, and we see that in the reality of our classrooms. When you are in a classroom as a teacher or going in as a support staff, and you have 16 children in the classroom, you may have three children who are completely disrupting that classroom, and for the most part those children have not been receiving the needed mental health services.

Senator QUAYLE. OK, I guess I would say I was just really surprised by that figure—80 percent of the children in the Manhattan Children's Psychiatric Center had previously been enrolled in the Head Start Program. Now, do you think that if we did this Manhattan project elsewhere that we would find the same statistical results?

Dr. HUTCHISON. Yes.

Senator QUAYLE. You think so.

Ms. Greene, I am just asking opinions.

Ms. GREENE. My feeling is I think that is an isolated case, and that it is extremely high. I do feel the low emphasis on mental health for our children needs more attention, needs more money, needs more training, but I do think that is isolated. I do not have facts to support it.

Senator QUAYLE. I am not disputing that. I am just curious about that figure.

Ms. GREENE. I do not think that that is the norm throughout this country.

Senator HAWKINS. I still think it is a discovery tool, and doesn't it say that if we had outpatient facilities, available, we would not have to institutionalize these children. We do not have outpatient facilities in most instances. You cannot go door to door and ring the doorbell and ask those people, not enrolled in the program, if they need help.

So it seems to me that if we did have more community programs, outpatient clinics, there would probably be more opportunity to prevent serious problems by catching them earlier.

Senator QUAYLE. Thank you, Madam Chairman.

Senator HAWKINS. Thank you for coming and for participating, and your interest and support.

Dr. Smith, what can be done in training child care workers to help prevent sexual and physical abuse? As I see the statistics that are out for reporting this year, over 50 percent——

Dr. SMITH. The statistics are not personnel working in child care centers in Head Start.

Senator HAWKINS. No, no, no. This is across-the-board. What can be done with the children; how do we detect it? You know better, because you do credentialing, and that is your responsibility.

What advice would you give us for all teachers?

Dr. SMITH. For all teachers, and for the children who have been abused?

Senator HAWKINS. For child care workers, to detect it.

Dr. SMITH. For detecting, OK. Because the training for child care workers focuses heavily on learning how children develop normally—emotionally, socially, and intellectually—observing children for their developmental progress is a critical part of training. When the child care worker, the Head Start teacher, has had that training, he spots difficulties. While the cause of the difficulty may not be evident, they know it is their responsibility to make referrals and obtain assistance.

Senator HAWKINS. Is there a payback in prevention, also, if your teachers are trained?

Dr. SMITH. Especially in the programs where the teachers work with the parents. There are parenting skills that can be enhanced. It is not a natural phenomenon to know how to parent successfully. To the degree that early childhood programs are achieving their goals, teachers are working very much in concert with the parents, helping them understand normal development patterns and parenting skills for these stages. We are beginning to understand that abuse of young children is frequently associated with adults not understanding normal behavior patterns and not knowing nonharmful, positive guidance techniques to use in responding to children's normal behavior.

Senator HAWKINS. What does it cost to get a CDA certificate?

Dr. SMITH. Let me ask Dr. Phillips to respond.

Dr. PHILLIPS. The cost to the individual is $325.

Senator HAWKINS. When we give that certification to workers in private corporations, do we make money on that?

Dr. PHILLIPS. When the individual is sponsored by the private corporation, the cost is borne by the private corporation. That constitutes program income outside of the grant support we receive through independent funding agencies. I would like to clarify this statement.

[Information supplied follows:]

Council for Early Childhood Professional Recognition
A Subsidiary of the National Association for the Education of Young Children
1341 G Street, N.W., Suite 802, Washington, DC 20005
202-638-6656 800-424-4310

March 11, 1986

Honorable Paula Hawkins
U.S. Senate
Washington, D.C. 20105

Dear Senator Hawkins:

In our testimony for the Hearing on the Reauthorization of the Head Start Program before the Subcommittee on Children, Family, Drugs and Alcoholism on February 27, 1986, you asked a question concerning the cost of CDA certification which was: "When we give the certification to persons from private corporations, do we make money on that?" My answer was that when the individual is sponsored by a private corporation, the cost of credentialing is borne by the private corporations, so that constitutes program income outside of the grant support we receive through independent funding agencies. I would like to clarify that answer.

The $325 credentialing fee is the same to any applicant whether the individual is sponsored by a private corporation or not. That $325 covers only the direct costs to the CDA program of the Local Assessment Team meeting: that is, the CDA Representative's fee and travel expenses and the small gratuity to the Parent/Community Representative. The credentialing fee does not contribute to the indirect costs of running the credentialing program, such as printing and mailing assessment materials and publications. Therefore, the fees are income to the program--by government definition they are program income--but we don't make money on them.

I hope this explanation will clear up any potential misunderstanding concerning the cost of CDA credentialing.

I appreciate your interest in and support of our important program.

Sincerely,

Carol B Phillips

Carol B. Phillips, Ph.D.
Executive Director

CBP/ph

Senator HAWKINS. So it is in the funding of your program.

Dr. PHILLIPS. Yes, it is.

Senator HAWKINS. Do you have any ideas how we can bring the cost of training down while preserving our quality control?

Dr. PHILLIPS. The cost of training?

Senator HAWKINS. Technical training.

Dr. PHILLIPS. That is one of the issues we are looking at this year. Until now, the National Credentialing Program has not been involved at all with training and the funds for training. So we really have no experience with looking at cost factors involved in training.

We will begin to examine some of those issues immediately. We have begun, in fact, to put a system into place to do that review.

Senator HAWKINS. Thank you.

We look forward to working with you. I am proud of all of your interest and your participation in what I think is one of the most important programs we have in the United States of America for the future.

Senator Dodd.

Senator DODD. Thank you, Madam Chairwoman, and I apologize to our witnesses here for coming in a little bit late on your testimony. I was speaking before the National Education Association this morning, Madam Chairwoman, so I apologize for being late.

I was curious, just in response to the last questions, because it is a problem with getting the credentials for teachers in this area, the Childhood Development Association credential.

We have not gotten very far with it but have in fact introduced, Dr. Smith, a piece of legislation a year or more ago. It was $1.5 million—it is not exactly what you would call a staggering sum—for a scholarship program, which is not going to resolve the problem. But I wonder if you just could comment on that particular aspect, what assistance or help you think such a proposal might be.

Dr. PHILLIPS. Well, we think that the Child Development Associate Scholarship Act that you refer to will be of great assistance to individuals who need financial support in applying for the credentialing.

In some cases we have seen not only the Head Start Program agencies make the decision to support their staff credentialing costs through their program funds; we spoke to this a little earlier; we have also seen an increase in the number of private employers who are willing to supply funds for training as well as credentialing.

Senator DODD. What does that cost? Have you any sense of what the cost would be? Obviously, it varies from individual to individual.

Dr. PHILLIPS. The credentialing cost is $325 for the individual.

Senator DODD. So that $1.5 million would actually go quite a distance.

Ms. GREENE. Excuse me. That $1.5 million also includes the cost of the actual training at the university level at the local community college. That is just the assessment fee.

Senator DODD. What do those costs run?

Ms. GREENE. Now, that varies from community to community. Many Head Start programs are able to negotiate with their local

community college to be charged just the actual cost of the cost per hour at that particular college, which then means they can serve more Head Start employees or parents. Then others have to negotiate a contract with the various universities or community colleges at a set fee that encompasses everything. So it varies from community to community. It is whatever you can negotiate with your local community college as to the cost of the training, and it is also how your program is set up.

Some Head Start's have it as a one-semester thing that encompasses all 13 areas. Others have it as 1½ years, with 3 semester hours. Others stretch it out into a 2-year program It is a locally designed option in terms of how you set it up, but it just has to have the 13 competency areas, and it must be credits that the person can have to transfer to a 4-year institution.

Senator DODD. What are some of the really good ones that you have seen? What are some models that you would suggest?

Ms. GREENE. Well, we could start with Manatee Community College in Bradenton, FL. I happen to think we have an excellent one there. We started out as soon as the first issuance came out about the program. The college was very receptive. Right now, the money is turned over to Head Start, versus most institutions take the contract and work up a plan. But our institution provides for Head Start, and there are three neighboring communities that utilize the program, and thus we are able to use more than the given slots. Like right now. in terms of each region, it gives so many slots per funding amount. We are able to stretch it as far as we can get it.

Senator DODD. What does it cost? What does it cost someone to go through that program?

Ms. GREENE. I think it is $32 per course hour, and our program is set up into 12 hours of training, and then the credentialing process, which is what they are speaking of, costs $395.

Senator DODD. Well, I misspoke when I was talking about the scholarship program. It would be the training cost, not just to pay for the certificates.

Dr. PHILLIPS. The training costs vary greatly as Sarah pointed out, depending upon the arrangements that have been made with the local training provider. And in some States, for instance, in California, where community colleges still remain by and large tuitionless to the student, the training costs can be very low. There is a registration fee that is required which I think is under $50 now, or there is a penalty fine if you withdraw from the course. There really is no tuition.

Where arrangements are made between Head Start programs or other child care organizations and those community colleges to deliver child care training, the training cost is really covered by the State through moneys that fund the local community college. In 4-year institutions, depending upon the tuition that is charged to the student, the costs can go much higher.

Now, we think that the best arrangements are ones with colleges and universities that are flexible enough to provide that training as part of their early childhood child development training, in ways that meet the time needs of the Head Start staff. And in some communities, those arrangements have been made that both benefit the college in terms of their ability to increase the number of stu-

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dents in their degree programs as well as to the Head Start Program or child care center which is taking advantage of a local preexisting training resources.

And through the CDA effort, many of those matches have been made between working professionals in child care centers and colleges and universities that perhaps would not have been nurtured otherwise.

Senator DODD. Now, can they do it as an on-the-job training kind of thing? I mean, can you do this simultaneously and so forth?

Dr. PHILLIPS. If the college is flexible enough to take a look at that as an option. Most child development training programs, for instance, require a practicum experience. They require that the student while in training have some hands-on contact with children for a certain number of hours. Where the colleges are willing to look at the on-the-job experience as a substitute for or as equivalent to those practicum experiences, then it benefits both the student as well as the college. And that has happened in some places. It simply is a very diverse situation across this country.

Senator DODD. Thank you very much for that.

Madam Chairman, if I can without taking any time, I would submit an opening statement; and also, there is a statement from Congressman Leland of Texas, who has asked that his remarks about Head Start be included in the record as well.

Senator HAWKINS. Certainly.

[The prepared statement of Congressman Leland follows:]

STATEMENT OF REPRESENTATIVE MICKEY LELAND

BEFORE THE SENATE LABOR AND HUMAN RESOURCES COMMITTEE
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOLHOLISM
FEBRUARY 27, 1986

SENATOR DODD, SENATOR HAWKINS AND MEMBERS OF THE SUBCOMMITTEE:

I APPRECIATE HAVING THE OPPORTUNITY TO PRESENT THIS STATEMENT ON BEHALF OF REAUTHORIZING THE HEAD START PROGRAM. HEAD START IS A PROGRAM THAT SAVES $4.75 FOR EVERY $1 INVESTMENT BECAUSE THE PARTICIPATING CHILDREN GROW UP HEALTHIER, MORE LAW ABIDING AND MORE SELF-SUFFICIENT THAN THOSE LOW-INCOME CHILDREN WHO DO NOT RECEIVE ITS COMPREHENSIVE PRESCHOOL EDUCATION AND SUPPORTIVE SERVICES.

THIS PROGRAM, NOW IN ITS TWENTY FIRST YEAR OF OPERATION, HAS GIVEN MILLIONS OF TODDLERS THE OPPORTUNITY TO GROW AND DEVELOP TO THEIR FULL POTENTIAL. IT IS A PROGRAM WITH DOCUMENTED ACHIEVEMENTS IN IMPROVING THE COGNITIVE SKILLS, HEALTH AND NUTRITION STATUS OF PARTICIPATING CHILDREN. MOST IMPORTANTLY, IT HAS ASSISTED THE CHILDREN AND THEIR FAMILIES IN RISING OUT OF POVERTY AND INCREASING THEIR SELF-ESTEEM, AND EMPLOYABILITY AND REDUCING THEIR DEPENDENCE ON PUBLIC ASSISTANCE.

IN 1964, AT THE REQUEST OF THE FEDERAL GOVERNMENT, A PANEL OF CHILD DEVELOPMENT EXPERTS DEVISED PLANS FOR A PROGRAM WHICH WOULD ADDRESS THE NEEDS OF DISADVANTAGED PRESCHOOL CHILDREN. A MEMBER OF THAT PANEL, DR. ROBERT COOKE, PEDIATRICIAN-IN-CHIEF OF JOHNS HOPKINS HOSPITAL, REPORTED:

> THERE IS CONSIDERABLE EVIDENCE THAT THE EARLY YEARS OF CHILDHOOD ARE A MOST CRITICAL POINT IN THE

> POVERTY CYCLE. DURING THESE YEARS, THE CREATION OF LEARNING PATTERNS, EMOTIONAL DEVELOPMENT, AND THE FORMATION OF THE INDIVIDUAL EXPECTATIONS AND ASPIRATIONS TAKE PLACE AT A VERY RAPID PACE. FOR THE CHILD OF POVERTY, THERE ARE CLEARLY OBSERVABLE DIFFERENCES IN THESE PROCESSES, WHICH LAY THE FOUNDATION FOR A PATTERN OF FAILURE, AND THUS A PATTERN OF POVERTY, THROUGHOUT THE CHILD'S ENTIRE LIFE."

THE REPORT SUBMITTED BY THIS PANEL FACILITATED THE CREATION IN 1965 OF AN EIGHT-WEEK PILOT PROJECT ENTITLED "HEAD START". SINCE THAT TIME, HEAD START HAS EVOLVED INTO A PRIMARILY YEAR-ROUND PROGRAM WHICH IS LOCATED IN RURAL AREAS, CITIES AND U.S. TERRITORIES. IT HAS GROWN INTO A MULTI-FACETED PROGRAM PROVIDING A MEANS FOR INVOLVING LOW-INCOME PARENTS IN THE EDUCATION OF THEIR CHILDREN; PROVIDING MEALS TAILORED TO THE NUTRITIONAL REQUIREMENTS OF PRE-SCHOOL CHILDREN; OFFERING NUTRITION EDUCATION SERVICES TO CHILDREN AND THEIR PARENTS; PROVIDING PARTICIPATING CHILDREN WITH A COMPREHENSIVE HEALTH CARE PROGRAM; AND CREATING A LADDER FOR THESE CHILDREN TO CLIMB UPWARD TOWARD EXCELLENCE.

WHILE THE HEAD START PROGRAM DOES NOT FOCUS PRIMARILY ON NUTRITION SERVICES, AS CHAIRMAN OF THE SELECT COMMITTEE ON HUNGER, I AM PARTICULARLY AWARE OF THE SIGNIFICANT IMPACT OF THE PROGRAM'S NUTRITIONAL COMPONENT. THE 1984 EVALUATION OF THE PROGRAM, PREPARED FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, REVEALED MANY UNDERNOURISHED CHILDREN WERE ENTERING THE PROGRAM. AFTER A BRIEF PERIOD OF ENROLLMENT, THESE CHILDREN WERE FOUND TO BE MORE LIKELY

TO EAT SUFFICIENT QUANTITIES OF FOOD THAN NON-PARTICIPATING CHILDREN. IN ADDITION, THE NUTRITIONAL QUALITY OF THEIR DIETS IMPROVED SIGNIFICANTLY AND WERE FOUND TO BE FAR SUPERIOR TO THOSE OF NON-HEAD START LOW-INCOME CHILDREN. THIS STUDY ALSO EXAMINED THE EFFECT OF THE PROGRAM ON HEAD START FAMILIES. IT WAS FOUND THAT THE NUTRITION EDUCATION COMPONENT OF THE PROGRAM PLAYED A VITAL ROLE IN IMPROVING THE DIETS AVAILABLE IN THEIR HOMES AND IN INCREASING THEIR FAMILIES' PARTICIPATION IN FOOD ASSISTANCE PROGRAMS AS NEEDED. FURTHER, A COMPREHENSIVE REVIEW OF EVALUATIONS OF THE HEAD START PROGRAM BY GEORGE WASHINGTON UNIVERSITY, REPORTED FEWER CASES OF ANEMIA AMONG CHILDREN IN HEAD START THAN AMONG NON-HEAD START CHILDREN.

IN JUNE, 1984, THE HOUSE SELECT COMMITTEE ON HUNGER HELD A HEARING AND FIELD INVESTIGATION IN GREENWOOD, MISSISSIPPI ON THE EFFECTIVENESS AND AVAILABILITY OF FEDERAL FOOD ASSISTANCE PROGRAMS IN THAT REGION. ONE OF OUR FIELD VISITS AFFORDED US THE OPPORTUNITY TO MEET WITH A GROUP OF HEAD START PARTICIPANTS, THEIR PARENTS AND TEACHERS. IT WAS HEART WARMING TO WITNESS THE POSITIVE ATTITUDES THESE CHILDREN EXUDED. WE LEARNED FIRSTHAND THE CRITICAL ROLE HEAD START PLAYS IN THEIR LIVES. HAD I BEEN ABLE, I WOULD HAVE GLADLY SPENT THE ENTIRE DAY WITH THIS GROUP.

AS YOU WELL KNOW, THE HEAD START PROGRAM REACHES LESS THAN ONE-FIFTH OF THE PRESCHOOLERS WHO ARE INCOME-ELIGIBLE TO PARTICIPATE IN THE PROGRAM. WHEN WE KNOW THAT ONE OUT OF EVERY FOUR PRESCHOOL CHILDREN LIVE IN POVERTY, WE HAVE ONLY ONE CHOICE TO MAKE IN THE REAUTHORIZATION OF HEAD START: COSTS OF LIVING ADJUSTMENTS MUST BE MADE FOR ALL HEAD START PROGRAMS AND THESE INCREASES MUST REFLECT THE ACTUAL COST TO MAINTAIN THE FISCAL YEAR 1985 PARTICIPATION LEVEL. ANY

LOWER AUTHORIZATION LEVEL WOULD THREATEN THE ABILITY OF THE PROGRAM TO PRODUCE POSTIVE LONGLASTING RESULTS.

WE MUST NOT FORGET THAT TODAY'S CHILDREN IN POVERTY--THOSE WHO ARE AFFORDED THE BENEFITS OF PARTICIPATING IN HEAD START AND THOSE WHO ARE DENIED THIS PRIVILEGE--ARE TOMORROW'S ADULTS. INVESTING IN THEIR FUTURE IS THE MOST VALUABLE INVESTMENT WE CAN MAKE.

Senator DODD. We celebrated the 25th anniversary in Connecticut, and they did around the country, of Head Start. And as the New York Times and other editorial pages across the country reported, this is really a fabulous program. The Head Start Program is a great success story. If you just look at those statistics, now that there are so many children over the years who have gone through Head Start programs, and those who did not have the opportunity to go through them, and just see what has happened to them, I mean, the evidence is right there. You do not need to have a long dissertation from Ph.D.'s or other people on the subject; it is just self-evident. This program has paid for itself over and over and over and over again.

My hope is we will continue to see to it, in this environment that we are in, that it gets the adequate amount of support and backing and funding.

I am delighted you are here today.

Thank you, Madam Chairwoman.

Senator HAWKINS. Thank you. We thank this panel.

Our next panel consists of Head Start participants, the people who can tell the committee how Head Start has actually affected their lives and those of their friends.

Mrs. Becky Price-Davidson is a Head Start graduate from Utah. Today, she is a student and soon to be a mother.

Also, we will hear from a constituent of Senator Dodd, Mrs. Maria Flores, and she is accompanied by Mrs. Rosalie Wilson, another Head Start mother.

We will save the questions until after both witnesses have given their statements.

Becky, you go first.

STATEMENT OF BECKY PRICE-DAVIDSON, HEAD START GRADUATE, AND STUDENT IN CHILD DEVELOPMENT AT UTAH STATE UNIVERSITY, LOGAN, UT, SPONSORED BY THE UTAH HEAD START DIRECTORS ASSOCIATION; AND MARIA FLORES, HEAD START PARENT FROM NORWALK, CT, ACCOMPANIED BY ROSALIE WILSON, HEAD START PARENT

Mrs. PRICE-DAVIDSON. Well, first of all, I would like to thank Senator Hawkins and Senator Dodd for letting me take this time.

I have put in a written statement. As far as the program, as far as I can remember when I went through it, it was about 2 years old. My brother went through it before I had, and so my mom was already quite active in the program. When my brother went through, he was quite shy, quite timid, and kind of in his own little world. He was a child who would cry constantly. My mother told me that in 7 weeks she noticed a difference between Quinn in the time that he went in, and that time period, that he started to come out and be more of a loving child, more open with people, and even though he is still quite shy, he did something quite good and useful with his life. Quinn went through the program at Bridgeland and is a carpenter and is now serving an LDS mission in Bristol, England.

As for myself, when I went through I was basically in my own little world, too. Everything was mine, mine, mine. I was quite self-

ish. They were able to help me through the program and break through that, as I have put in my written statement.

I remember all of the ideals that they taught me, and I quite appreciate it because I can kind of compare what life would have been like without Head Start. It would have been very difficult for me, because of the world that I had kind of built around myself.

Now I am starting my own family. I started at Utah State in early childhood education. But because of poor health, I was forced to quit for a while until after May when I have my baby, and then I will continue on.

As far as what it did in our home, I was quite young, but I can still remember the peace that it brought into our home, and my mother has said the same. It brought our family closer together, because we all had to work together to let my mother go and participate in the program, and so in that way, it brought our family real close together. It did help our family.

My sister also was able to have her family participate in the program, and I could see all the changes that happened in my niece and nephews. It helped their family a great deal, too, to be able to go through the program.

I do know that when they did cut the funds a couple of years ago, especially in the program that is in Logan, the busing system had to be cut out, which kind of put out some of the children that do need the program, because they are not able to go. They have no way to get there. If they are to be taken, they are to be taken by their mothers or fathers, and they have to be picked up. And in that way, most of the people that should go cannot afford to take their children.

So I would urge us to put everything we can into education. Children learn at a very young age. And I support the program. I have been through it. It is a very good program. And I urge you to support it and the reauthorization of Head Start.

Thank you.

Senator HAWKINS. Thank you, Becky.

[The prepared statement of Mrs. Price-Davidson follows:]

Written Testimony of Mrs. Becky S. Davidson,
Former Head Start student

My name is Becky Sherlauna Price-Davidson. I was born in Logan, Utah on July 6, 1966. I am the youngest of nine children.

My parents are Aaron and Thora Price. They live on a small farm in Cache Valley (Wellsville), Utah. My father is retired from Hill Air Force Base, where he was a mechanic on various aircrafts.

I am now nineteen years old. On June 21, 1985, I married Weston Davidson in the Logan Utah L.D.S. Temple. My husband is attending Utah Technical College in Provo/Orem, in the machinist program. We lived in Provo and expect our first child in May, 1986. I have moved to Logan to attend full time at Utah State University. I started 1986 Winter Quarter in Early Childhood Education. Because of poor health, I wasn't able to finish the quarter.

I've always enjoyed being around and teaching young children. Children seem to be able to teach me just as much as I'm able to teach them. I've been involved in different programs which enabled me to teach kindergarten and at various pre-schools. The best reward in working with children is seeing the different points of development while they're still so very young.

In June, Weston will be finished with the program at Utah Technical College. He will then join me in Logan, where we both plan on continuing our education at Utah State University.

My family was first involved with Head Start when the program was just beginning. One of the teaching-aides came to our home and introduced the program to my mother. When my mother was asked if she'd like to be involved in Head Start, with her four year old son, she gladly agreed.

My brother, Quinn, cried continuously from day one. He was a very insecure child. Doctors had no explanation for his behavior. He seemed to live in his own fantasy world and would always suck his thumb.

After seven weeks at Head Start, my mother noticed that Quinn began to be a happier little boy. As time went on, he became more loving and didn't seem to need his "fantasy world" as much.

My mother, quite often, would volunteer her time. I remember going sometimes with her and my brother. My family would help with the house work so she could work at Head Start. In order for my mother to work with the program, she got more schooling in child psychology. She also was involved with the parenting group that decided on what curriculum they wanted for their children.

She told me that everything she learned through Head Start, helped her teach at home. Even though I was only three, my mother and I noticed a certain peace in our home. Mother noticed that our family had pulled closer together in love.

My mother claims that Head Start came seven children too late for her. She said, "The day that one of the Aides came

knocking on our door, was one of the best days of my life". Quinn is now serving a L.D.S. mission in Bristol, England.

When I was four, I was finally able to attend. Mrs. Glenna Markey was our teacher. Miss Colleen Jackson worked with the problem children and assisted Mrs. Markey. The class ran Monday through Thursday at 8:30 a.m. until 11:30 a.m.

I remember thinking that 7:00 a.m. was pretty early to have to get up for school. My mother would just finish the wringlets in my hair when the bus would arrive. The bus would often wait for me when I wasn't quite ready to go.

Being the youngest child, I'd learned to fight for what I wanted and was quite selfish. Since I was bigger than the other kids and had sometimes attended with my brother, I thought I pretty much owned the place. I loved being able to go but would fight everyone that would get in my way.

I remember the day they finally broke through my selfish temper tantrums. They had all of the kids playing in the gym. I had been playing with "my" tricycle. When it came time to share with another little boy, I threw a fit and started in fighting. One of the Aides pulled me to the swings and explained why it was necessary to share. I was still crying when we got back into the room so they put me into the "time-out-chair". I pretended that I'd fallen asleep and thought about what my mother and all the teachers had been saying towards correcting my behavior. I got up, to go to snack time, thinking I'd try my best to behave well. The compliments I'd recieve on my behavior reinforced my actions.

I also remember being taught many ideals. For instance:
MANNERS: How to say please, thank you, and how liquids are eaten out of a bowl with a spoon as well as other eating habits.
CLEANLINESS and PERSONAL HYGIENE: Getting dressed, tie a shoe wash and dry my hands, brush and care for my teeth and hair, and using a tissue to blow my nose.
MOTOR and CORDINATION SKILLS: Running in competitive races, playing inside or outside on the slide, swings, tricycles, teeter-totter. The art projects would teach us eye to hand cordination. I remember learning to use scissors, crayons, glue, writting skills, and my most favorite, working with paint. One of the painting projects we did, we were to be very careful so we would not get paint spilled on us. A few children became restless and spattered paint on some of the other kids and me. I felt so embarrassed running around in pants that were to little and nothing else on. They had kept extra clothes around for the needy children, but, had made sure from that time on that the parents brought extra clothes for their own child.
OBEDIENCE and SAFETY: We were taught to sit quitely on the rug or we were put on a chair. We also learned how to carry sharp objects and handing them to other people. The teachers would talk about the way we should act towards strangers and about traffic safety. They would take us for a walk around the block to

practice safety habits. I enjoyed showing everyone how much I knew about crossing corners.
SOCIAL HABITS: I loved being with the other children. It made me feel so important. Everyone I've talked to has agreed that the social habits that their children learn is the best part of the program.

Every Wednesday, we would have a field trip. We'd all get on the bus and go to different places like: grocery stores, the cheese plant, a fish farm, a dairy farm, and even to the airport. When we visited the airport, they had a small airplane rented. Each of us went up in the airplane. I've loved flying every since that day!

Thinking back on all I've learned in Head Start, I realize how much I've learned and how my family and I have gained. I also have been able to speak with my two sisters and my brother-in-law about their families' experiance with Head Start.

My one sister, Janet, had her daughter in the program. They live in Cheyenne, Wyoming. I was very disappointed that Janet thought that the program was just a babysitting service.

My other sister and her husband had both liked Head Start. They had both driven the bus for Head start. Paulene drove for three years and Lloyd for five years. Paulene had also done some volunteer work and went to the parenting and CPR classes. When Paulene had her new job, Lloyd would go to Logan with her to get the bus.

They had four children and only the eldest child didn't go through the program. Jason was the first one to go. He had to be taught self-control. Then Jennifer was alot like me, quite selfish. Jeremy was a backward child, very quite.

After seeing their children's progress, they were both pleased. They both told me that it is a worth while project. Lloyd said, "Lots more kids needs more help". He also stated how many cases of child abuse can be found and helped.

Paulene told me that she was worried that the poverty level wasn't receiving the help from the program now as much as in the past. In her experience, she's seen many children were let in because they'd had older brothers or sisters in Head Start before. She didn't like having children in Head Start only because their families had connections. She also thought that the money spent on field trips should be used for kids in the elementary ages. Paulene told me that since they cut the funds, the busing system was no longer feasible. Now those who can afford to bring their children to Head Start are the ones that recieve the service. But those parents who can drive their children, can usually afford to take their children to another pre-school. The parents that can't afford to drive their children are the ones that should be involved. Paulene said, "They ought

to get back the funds to run the bus and make sure the poverty level recieves the service". I agree with her. "In all, it is a good program", she said.

In closing, I would like to thank you for the honor of allowing me this opportunity. I know that Head Start has helped my family considerably. The benefits that I and others have recieved from Head Start, makes it one of the most significant programs today. I also feel that too many funds are taken from our children's education. There should be much more put into education. Too much is taken away. Head Start has helped many people and should be more available to those at the poverty level thoughout the continuing years. I support the Head Start program and urge you to continue to improve and support the program to give our neediest children and families the opportunities that I, my family, and others have experienced.

Senator HAWKINS. Mrs. Flores.

Mrs. FLORES. Good morning.

My name is Maria Flores, and I have been a parent in the Norwalk Head Start Program for 2 years.

I am here to ask that the reauthorization bill for the Head Start Program be awarded so that other mothers like myself have the opportunity to develop their potential and self-esteem as I did.

My involvement in Head Start has helped me develop confidence to leave the welfare program, to further my education in search for a job that will make me self-sufficient. It has also helped me develop the ability to express my thoughts in public.

Before I was involved in Head Start, let me tell you what my day was like. I would get up in the morning and get my kids ready for school. Then I would do some house cleaning and watch TV most of the day. When the kids returned home, I would feed them, bathe them, watch some more TV, and then go to sleep. Most of my weekends were spent inside the house, cleaning, washing, being with my kids, and watching TV. I never took the kids outside to play.

Today, my life is very different. Being with Head Start has given me the confidence to trust my own abilities—to learn that there is a place for me out there in this society. I am presently attending CPI, the Computer Program Institute, in the morning, while my kids are in school. I have also enrolled in ETAP, a typing class at NEON, our grantee agency, and I am taking my GED classes in the afternoon at NEON, too.

These changes in my life started when I took my kids to the Norwalk Head Start Program. When my kids began school there, I was invited to come to school with them. I joined the GED class which was right in the school. I went to class upstairs, and my kids were downstairs in class.

I started attending parent meetings that are held every week. We had training on child development, drug abuse, child abuse, community agencies, and things like that. I met other parents there that were looking for the same things that I was. I liked being on the advisory committees, which helped to plan better ways to make the program work. Then I finally joined the policy council, which is the parent committee that has to do with all the plans and activities at Head Start. Then I learned how the Head Start Program really works.

I want you Senators to know that this is the first time I have been here in Washington, DC, and I cannot believe that I am here now, sitting in front of you, talking like this.

My friend, Rosalie Wilson, came with me. She is a parent in the program, too, and she cannot believe she is here, either.

So you see, Head Start does help families—not just our kids—I am here to prove it.

Thank you.

Senator DODD. Very good.

Senator HAWKINS. Thank you for a beautiful statement.

I think that probably a well-kept secret in the United States of America is how wonderful this program is for parents. The programs that I have visited, the memories that I take away are of the mothers with the children, holding their children's hands, and

other children in their laps, and learning skills that help them to become leaders, and of the policy committee, which is fantastic. It does make a difference in quality of life, and I really am thrilled to be part of reauthorizing a program that has had such a fantastic record since 1965. As you look over the humble beginnings, the controversies surrounding the program—I guess every time we go to reauthorize it, we have a little less controversy—but our success record is fantastic, and now that child care is uppermost on everybody's mind, I am happy that this program has already set standards and has a fantastic success record that we can point to with pride. It is just a fantastic American story.

And we are glad, Mrs. Wilson, that you came with Maria today. We had the snow today especially for Connecticut and Utah people. I am not impressed. I remember why I moved to Florida, where it is 78 and the Sun is shining today. [Laughter.]

Is there anything that you would like to tell us, Mrs. Flores, as an advisory board and policy council member that you have heard here today—you have gotten a glimpse from the experts, from the head of the department all the way down. It is quite an educational day for the Senators, and I am sure you both, you and Becky, have enjoyed the testimony you have heard.

There are a lot of Senators who sit on this committee, but we are all members of a lot of committees and in and out most of the time. It is not a lack of devotion or dedication or interest that they are not here, and hopefully they will read your statements.

But I would just like to know from a hands-on person who is working in the program right now, Mrs. Flores, and also with children in the program, is there anything you could tell me about how we could improve the program?

Mrs. FLORES. Well, I learned a lot from the advisory committee, like I said in the statement. At the beginning, when I went there, I could not understand—my kids did not know English, and they could not speak well with the other kids, and they did not know what to do. So when they started school, it was very nice, because the teachers helped them to be friendly with other kids, and they showed them different things.

So when I went to the advisory committee, I started seeing how the teachers worked with the kids and how they educated them And I think that the advisory committee really works good with the kids and with other parents.

Senator HAWKINS. Would you like to share some of the things that you learned in Head Start that helped you as a parent?

Mrs. FLORES. Well, first, what I learned is how the program works, how Head Start works. We have the policy council. If we are going to do an activity or something, that goes to the policy council. We sit down, we talk about it, we decide if it is OK, and with other activities it is the same thing. So I learned a lot about it. I really learned how to involve myself in other things.

When I first started there, it was difficult for me. When I started there, I felt like this was not my place to be. But once I kept going over there, I saw that it was like a family reunion. Everybody was nice with me, I started opening up, and then I said, now I have to do something else for me and my kids, and give them a better education and give myself a better education and get a better job so I

can support them and do other things in life, not just being involved here.

Senator HAWKINS. Do you enjoy your children more?

Mrs. FLORES. Yes. I have less time with them, but I enjoy them more now. [Laughter.]

Senator HAWKINS. That is rather normal. What did your child think the first time you took the child to Head Start? You have told us how you feel. Now tell us what the child said.

Mrs. FLORES. My kids like the way I am doing it now because before, like I said in the statement, I used to be in the house most of the time I never went out. I was afraid to take them outside, take them out into the world.

Now it is different, and I take my kids to other places, and they enjoy themselves like I do.

Senator HAWKINS. Becky, you say you are going back to school after your baby comes. How do you plan to pay for your tuition?

Mrs. PRICE-DAVIDSON. Now, as it stands, I am getting some help from the Government, the Pell grant. And hopefully, after my husband graduates this May—he is in the machine program at Utah Tech—then we can start paying our own way. But as it stands, I am now receiving the Pell grant.

Senator HAWKINS. Thank you.

Senator Dodd.

Senator DODD. Thank you, Madam Chairwoman.

First of all, I am delighted all of you are here, and your statements are really wonderful, as Senator Hawkins has said. And with all due respect to the professional witnesses who do an excellent job as well, I think we learn so much more when we have a chance to talk with people like yourselves who are really in the program and see how it works.

One thing that Senator Hawkins may be interested in—and maybe, Maria, you can explain this a little bit—but one of the things they do in the Norwalk Program is there is a door-to-door recruitment program for Head Start.

I wonder if you might tell Senator Hawkins a bit about that and how that recruitment program works. Are you familar with that, Maria?

Mrs. FLORES. Well, when my child was enrolled in Head Start it was like that; they went to my house, and I heard about it.

Senator DODD. They came to your door?

Mrs. FLORES. Excuse me, no. They came to my cousin's door, and she told me about it. At first I said that I did not know anything about Head Start, and I said, "No, my kid is not going to go to Head Start."

But then, when I saw that her child was going, and he was learning more, and he was getting more prepared to go to school, then I got interested, and I went to Head Start. And I have seen the work that they have done. I have seen the social workers. They go to the houses. Some parents are interested in it. Other parents are, I guess, insecure.

Senator DODD. Do they use any of the parents in the program? Have you been asked at all to help go around and recruit families and talk about the program, rather than having someone like a social worker go, whereas you are maybe better able to relate to a

family, having been in the same position? Do you do any of that, or do the other parents do it?

Mrs. FLORES. Well, I have not gone to houses, but I have been the interpreter for some parents who have come to Head Start to enroll their kids. And they explain how the program works; they explain the things that their child will be learning. And at the end of the year, we see all the progress that our kids really learn and how it works.

Senator DODD. Well, again, as the chairwoman said—and I said "25 years" before; I guess that was wishful thinking, but it is 20 years—it is still a great success in 20 years. And I know there were ceremonies all across the country for the programs. We had several of them in Connecticut and one down here, and they really were great days. We had a wonderful one in Waterbury, CT, that was really exciting. People who are now adults who were in the Head Start Program themselves came back and talked about the early days, and it was really wonderful.

Anyway, we thank you for coming down. You have come a long way from Norwalk, and we are delighted that you are here, and you have done very, very well as a witness before the U.S. Senate, Maria.

Mrs. FLORES. Thank you.

Senator HAWKINS. And we should not neglect Mrs. Rosalie Wilson.

Senator DODD. No, I know. Do you have anything, Rosalie, that you wish to add at all to any of this?

Senator HAWKINS. Yes, Rosalie; you are from Connecticut, and maybe you would just like to answer the same question. What was your life like when you came to the program?

Mrs. WILSON. Well, I was a single parent, and it was basically just like Maria. When I enrolled my first daughter into Head Start, I did not know anything. I just thought I would put her in school, and that was it; I could sit home, lay back, and watch TV, and not have to worry about it.

And then the worker—each parent is assigned to a worker, and they call you—and she called me one day and she said, "There is a meeting going on. Why don't you just come in?"

And I said: "no, no. I do not know what that stuff is about. I do not understand it."

And she said: "Just try it."

So I said, "All right." And for the last 5 years, I have been there, and it has done wonders for me, for me to handle my kids better and understand them more, and it has been wonderful for my kids—I have three now—and I can see a change in every one of them from what it has done. And I can see a heck of a lot better change in me as a person. I can understand myself better, and I can understand other people better.

And without that, I would not be sitting here, talking to anybody—no way. [Laughter.]

They really helped me to just deal with myself.

Senator HAWKINS. Not everybody gets to be a witness before the U.S. Senate, and you will have a lot to tell your children when you go back.

I am impressed by the gratitude you have for the program as well as the understanding that it was a hand up not just for your children, but that you are now off welfare and looking toward becoming a productive citizen of the United States. That is what this is all about, and we wish you well, and a happy, healthy baby, Becky.

Mrs. PRICE-DAVIDSON. Thank you.

Senator HAWKINS. And stay in touch with us, if you have any suggestions for us. I like to talk with the hands-on people and see how this works in diverse places—Florida, Utah, and Connecticut—we ought to be able to get a handle on it.

[Additional material supplied for the record follows:]

THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

JAN 9 1986

The Honorable Thomas P. O'Neill, Jr.
Speaker of the House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker:

Pursuant to the Head Start Act (Section 635 et seq. of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35), 42 U.S.C. 9831 et. seq., I am transmitting to you the Twelfth Annual Report of the Department of Health and Human Services on the Status of Handicapped Children in Head Start Programs. Section 640(d) of the Head Start Act requires that "the Secretary shall report to the Congress at least annually on the status of handicapped children in Head Start programs, including the number of children being served, their handicapping conditions, and the services being provided such children."

This report describes Head Start services to handicapped children during the 1983-1984 program year. During 1983-1984, children professionally diagnosed as handicapped accounted for 12.5 percent (59,335) of the total enrollment in Head Start programs. More detailed findings are highlighted in the summary of the report.

This report contains no policy issues or recommendations.

I am pleased to transmit this annual report to you and to assure you that the services which have been provided to handicapped children in Head Start are of benefit to them.

Sincerely,

/s/

Otis R. Bowen
Secretary

Enclosure

THE STATUS OF HANDICAPPED CHILDREN IN HEAD START PROGRAMS

TWELFTH ANNUAL REPORT OF THE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
TO THE CONGRESS OF THE UNITED STATES ON
SERVICES PROVIDED TO HANDICAPPED CHILDREN
IN PROJECT HEAD START

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Human Development Services
Administration for Children, Youth and Families
Head Start Bureau
Washington, D.C.

1985

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THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

FOREWORD

For two decades the Federal government has been making a sustained involvement in our country's future by its Head Start program of today.

Since its inception, Head Start has provided comprehensive developmental services to low income preschool children and their families. The program seeks to foster the development of children and enabled them to deal more effectively with both their present environment and later responsibilities in school and communities. Head Start programs emphasize education, social services medical, dental, nutrition and mental health services and parent involvement to enable each child to develop to his or her highest potential.

One facet of the Head Start program merits a special salute: its service to handicapped children.

Since 1972, Head Start has mounted a major effort to serve handicapped children. The number of handicapped children enrolled in Head Start has risen steadily since the data were first reported from 22,807 in 1973 to 59,35 handicapped in 1984.

Head Start is in the forefront of the provision of services to the preschool handicapped child. Mainstreaming provides handicapped children with active, day-to-day group experiences with nonhandicapped children. Giving handicapped children an opportunity to learn, to play, and to live with nonhandicapped children enables them to take a giant step in the direction of participating in the general society as responsible adults in their later years. During the early, crucial years of growth, it is important for children to develop healthy attitudes and perceptions about each other, and themselves. Mainstreaming helps children reach that goal.

In 1984, 98.6 percent of all Head Start programs had enrolled at least one handicapped child. These children received a full range of child development services in addition to special education or related services in accordance with their needs. These special services were provided through the Head Start program, through outside agencies or through a combination of both.

This Administration believes in Head Start. We will continue to support comprehensive services which improve the quality of family life. It is through an alliance -- a working partnership -- between the Head Start program, community resources and State and local government agencies, that we can best make an important contribution to the lives of preschool children and their families.

/s/

Otis R. Bowen
Secretary

SUMMARY

Section 640(d) of the Head Start Act (Section 635 et seq. of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35, 42 U.S.C. §9835(d)), requires "that for fiscal year 1982 and thereafter no less than 10 percent of the total number of enrollment opportunities in Head Start programs in each State shall be available for handicapped children, and that services shall be provided to meet their special needs." This section continued a mandate first made a part of the Head Start legislation in 1974. In addition, the Head Start Act adopts the definition of handicapped children provided in paragraph (1) of section 602 of P.L. 91-230, the Education of the Handicapped Act, as amended, (20 U.S.C. §1401(1)). That Act defines the term handicapped children as "mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children or children with specific learning disabilities who by reason thereof require special education and related services." Outside the scope of this definition are children with correctable conditions who do not need special services or who will not require altered or additional educational or support services.

Handicapped children must meet the eligibility requirements for Head Start programs. Eligibility refers to the ages of the participating children (between three years and the age of compulsory school attendance) and family income (at least 90 percent of the children must be from low income families, including families receiving public assistance).

It has been estimated that there are 258,200 Head Start eligible handicapped children of preschool age (3-5) in the United States. Although there are various programs available to assist handicapped children, Head Start continues to make a notable contribution, particularly for those handicapped children who can benefit from a comprehensive developmental experience in a mainstream setting, one that integrates handicapped and nonhandicapped children. The number of handicapped children enrolled in Head Start has risen steadily since the data were first reported from 22,807 in 1973 to 59,335 handicapped children in 1984.

This report is based on data from the Handicapped Services section of the Project Head Start 1983-1984 Annual Program Information Report (PIR), as well as other supplementary data. The PIR was completed by Head Start programs in June 1984. Therefore, the data used in this report are frequently cited as 1984 data, although the report covers program year 1983-1984. This report discusses the status of handicapped children in those Full Year Head Start programs in 1983-1984 that responded to the PIR survey (nearly 100 percent responded). Almost all Head Start programs are full year programs that operate eight to twelve months of the year. There are 36 Parent and Child Centers (designed to serve children 0 to three years of age and their families) that are not included in the survey.

Highlights are:

- The number of handicapped children served by Head Start programs increased by 4,431 children from the previous year to 59,335 in 1984.

- Children professionally diagnosed as handicapped accounted for 12.5 percent of the total enrollment in 1984. By comparison, in 1983, children professionally diagnosed as handicapped accounted for 11.9 percent of the total enrollment in full year programs.

- An additional 11,665 children who had been referred by Head Start programs for diagnosis, but had not yet been professionally diagnosed, represent 2.5 percent of the total Head Start enrollment.

- The statute requires that 10 percent of the total number of enrollment opportunities in each State must be available for handicapped children but it does not require an actual enrollment of 10 percent handicapped children. However, one objective of the Administration for Children, Youth and Families (ACYF), which administers the Head Start program, is to achieve at least a 10 percent enrollment level of handicapped children in each State. In 49 of the 50 States and the District of Columbia, children professionally diagnosed as handicapped accounted for at least 10 percent of all Head Start enrollment in 1984. Only Alaska fell short of the 10 percent enrollment level with 8.8 percent handicapped children enrolled. In the prior year, Texas fell below the 10 percent level, but achieved the 10 percent level in 1984 with ACYF assistance.

- The distribution of handicapped children in Head Start, categorized by primary handicapping condition, is: 61 percent speech impaired, 12.1 percent health impaired, 5.9 percent physically handicapped, 5.7 percent specific learning disabled, 5.1 percent mentally retarded, 4.6 percent seriously emotionally disturbed, 2.9 percent hearing impaired, 2.2 percent visually impaired, 0.3 percent deaf, and 0.2 percent blind.

- In 1984, 17.2 percent of the handicapped children enrolled in the reporting Head Start programs had multiple handicapping conditions. Some 18.5 percent of the handicapped children served required almost constant special education or related services, 51.5 percent a fair amount, and 30 percent little or some of these services. The proportion of children reported as requiring almost constant special education or related services reflected a slight increase of 1.2 percent over 1983.

- In 1984, 98.6 percent of all Head Start programs had enrolled at least one handicapped child.

- There were 919 programs (52 percent) that reported 5,511 handicapped children that were located by or referred to them that they were not able to enroll. The reason most frequently reported was that of not fitting age requirements (39.4 percent). The percent of such progams is slightly lower than in 1983 when 53.1 percent of the programs reported 5,429 handicapped children that they were not able to enroll.

The enrollment and mainstreaming of handicapped children has become a characteristic feature of local Head Start programs. In 1984, only 24 out of 1,767 Head Start programs served no handicapped children. Head Start continues to be the largest program that includes preschool handicapped children in group experiences with nonhandicapped children on a systematic basis, i.e., that mainstreams preschool handicapped children.

Preschool programs that mainstream handicapped children give disabled children a chance to learn and play with children who will someday be their co-workers, friends, and neighbors. Both groups benefit most from being together on a regular basis during the years when their attitudes and perceptions of themselves and others are most pliable. In addition, the handicapped child begins to develop a sense of control over his or her own life and an ability to function among other people in spite of his or her disability.

There are some handicapped children who, for a variety of reasons, may do better at first in a non-mainstream environment or a home-based program. Others may benefit from a flexible approach and may spend part of the week in a special program and part in a mainstream program. Head Start policy requires that the handicapped child be placed in a mainstream classroom setting as soon as appropriate.

Handicapped children enrolled in Head Start programs received the full range of child development services required for all children in the Head Start Program Performance Standards as published in 45 CFR Part 1304. These include education, parent involvement, social services, and health services (medical, dental, nutrition and mental health). In addition, they received the special education and related services required by the Head Start legislation. Some 94.3 percent of the Head Start programs reported special efforts to enroll and serve more severely handicapped children. Programs provided assessment and diagnosis to evaluate accurately the nature and severity of each child's handicap in order to serve the child most effectively.

Head Start programs reported a number of special services provided to parents of handicapped children, including counseling; referrals to other agencies; visits to homes, hospitals, etc.; parent conferences with technical staff and other parent meetings; transportation; literature and special teaching equipment; workshops; medical assistance; and special classes.

Head Start and other agencies and organizations concerned with handicapped children coordinate efforts in order to make maximum use of their limited individual resources. Head Start programs reported working with other agencies in several ways:

- 43 percent of the handicapped children were referred to Head Start by other agencies or individuals; 20.7 percent of the handicapped children were referred and professionally diagnosed prior to Head Start.

- 64.5 percent of the children received special education or related services from other agencies.

- 95.8 percent of the programs had written or informal agreements with local education agencies or other agencies regarding services for handicapped children, reflecting a slight decrease over those that so reported in 1983 (97.4 percent).

Head Start programs also utilized volunteers and staff provided by outside agencies to meet the special needs of handicapped children. During 1983-1984, Head Start programs utilized 9,403 volunteers to provide special assistance to handicapped children, an increase of approximately 63 volunteers over the previous year. Programs also reported utilizing 6,404 staff from outside agencies, 5.6 percent more than last year.

Eight program manuals are being utilized to assist teachers, parents, and others such as diagnosticians and therapists in mainstreaming handicapped children. The series was developed in collaboration with teams of national experts and Head Start teachers, under the direction of the Head Start Bureau in the Administration for Children, Youth and Families (ACYF).

Head Start programs were also involved in several national efforts to serve handicapped children. Under the Education for All Handicapped Children Act of 1975 (P.L. 94-142), each State's allocation figures are based on the number of handicapped children, 3 through 21 years of age, currently being served (20 U.S.C. §1411(a)(1)(A)). As a major provider of services to preschool handicapped children, Head Start program personnel worked with local education agencies to ensure that children who had been professionally diagnosed as handicapped and who were receiving Head Start services were included in the State "Child Count." In addition, Head Start programs coordinated their searches for unserved handicapped children with the Statewide "Child Find" efforts required under P.L. 94-142. Head Start personnel also utilized other resources such as the Medicaid Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

The purposes of P.L. 94-142 are carried out in Head Start where handicapped children are given an opportunity to interact with children of varied abilities, needs and talents. Additionally, the Head Start program provides the special education or related services required by handicapped children.

ACYF has also funded a network of projects called Resource Access Projects (RAPs) to provide training and technical assistance to Head Start grantees to enable them to serve handicapped children and their families. In 1977, an interagency agreement between ACYF and the Office of Special Education in the Department of Education designated the RAPs as liaisons between Head Start and the State Education Agencies (SEAs). The RAPs have been facilitating the participation of the grantees in the development of State plans for preschool handicapped children as required under P.L. 94-142. Formal collaborative agreements describing how Head Start and SEAs will coordinate services to preschool handicapped children are now in place in 40 States or territories.

To ensure optimal transition by handicapped Head Start children into public school, Head Start personnel help parents participate in developing an Individual Education Program (IEP) for each handicapped child.

CHAPTER I

Handicapped Children in Head Start
Background Information

A. Purpose of this Report

This is the Twelfth Annual Report to the Congress on Head Start Services to Handicapped Children. Pursuant to the Head Start Act (Section 635 et seq. of the Omnibus Budget Reconciliation Act of 1981, P.L. 97-35), this report is to inform the Congress of the status of handicapped children in Head Start programs, including the number of children being served, their handicapping conditions and the services being provided to them.

B. Overview of Head Start Policies on Services to Handicapped Children

Section 640(a) of the Head Start Act (42 U.S.C. §9835(a)) requires "that for fiscal year 1982 and thereafter no less than 10 percent of the total number of enrollment opportunities in Head Start programs in each State shall be available for handicapped children and that services shall be provided to meet their special needs." The data presented here reflect Head Start efforts to respond to this legislative mandate.

In addition, the Head Start Act specifies the definition of handicapped children provided in paragraph (1) of section 602 of P.L. 91-230, the Education of the Handicapped Act, as amended, (20 U.S.C. §1401(1)). That Act defines the term handicapped children as "mentally retarded, hard of hearing, deaf, speech or language impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children or children with specific learning disabilities who by reason thereof require special education and related services." Handicapped children must meet the eligibility requirements for Head Start programs. Eligibility refers to the ages of the participating children (between three years and the age of compulsory school attendance) and family income (at least 90 percent of the children must be from low income families, including families receiving public assistance).

In response to the Congressional mandate to strengthen Head Start efforts on behalf of handicapped children, the Head Start Bureau located in the Administration for Children, Youth and Families (ACYF) in the Department's Office of Human Development Services has given priority to assisting local Head Start efforts to identify, recruit, and serve handicapped children. These efforts are consistent with Head Start's philosophy of responding to the unique needs and potential of each child and his or her family. Head Start policies that relate to handicapped children are:

1. Outreach and Recruitment - Head Start programs are required to develop and implement outreach and recruitment activities, in cooperation with other community groups and agencies serving handicapped children, in order to identify and enroll handicapped children who meet eligibility requirements and whose parents desire the child's participation. No child may be denied admission to Head Start solely on the basis of the nature or extent of a handicapping condition unless there is a clear indication that such a program experience would be detrimental to the child.

2. Needs Assessment, Screening and Diagnosis - Needs assessment, screening and diagnostic procedures utilized by Head Start programs address all handicaps specified in the legislation in order to provide an adequate basis for special education, treatment and related services. Head Start programs must ensure that the initial identification of a child as handicapped is confirmed by professionals trained and qualified to assess handicapping conditions. Assessment must be carried out as an on-going process that takes into account the child's continuing growth and development. Careful procedures are required, including confidentiality of program records, to ensure that no individual child or family is mislabeled or stigmatized with reference to a handicapping condition. Emphasis is placed on ensuring that the needs of all eligible handicapped children are accurately assessed in order to form a sound basis for meeting those needs.

3. Diagnostic Criteria and Reporting - In 1975, Head Start, the Office of Special Education (formerly the Bureau of Education for the Handicapped) in the Department of Education and other agencies that serve handicapped children reviewed the criteria then being used by Head Start for reporting purposes. Based on that review, an expanded set of criteria were developed which included the addition of a "learning disabilities" category in order to be consistent with P.L. 94-142, the Education for All Handicapped Children Act of 1975, as amended, (20 U.S.C. §1411(a)(1)(A)). The revised criteria also clarified the reporting of "multiple handicaps." Furthermore, the criteria were specifically tailored to the developmental levels of the preschool population, aged 3-5.

   In 1978, malnutrition was deleted from the "health impairment" category. A careful review of this category indicated that the inclusion of severe malnutrition was inconsistent with other conditions included under "health impairment." Since then, malnutrition has been dealt with as part of the overall health services reporting and evaluation.

   Since program year 1981-1982, the reference to "autistic" children has been deleted from the category "serious emotional disturbance" and added to the category "health impairment" for the subsequent reporting of handicapped children in Head Start. This was done in accordance with the regulation issued in January 1981 by the Secretary of the Department of Education that made changes in the definition of "handicapped children" under the Education of the Handicapped Act, as amended by P.L. 94-142.

   Appendix A presents the diagnostic criteria used in reporting handicapping conditions of the children in 1983-1984 Head Start programs.

4. Severely and Substantially Handicapped Children - Head Start policy distinguishes between two groups of children: children who have minimal handicapping conditions and do not require special services (e.g., children whose vision with eyeglasses is normal or nearly so); and those children who are handicapped, as defined in the legislation and who, by reason of their handicap, require special education and related services (see Appendix A). The purpose in making this distinction is so that only children who require additional education or support services can be counted for the purpose of the 10 percent enrollment opportunities requirement. Head Start considers

the children who need special services, namely those whose handicap cannot be corrected or ameliorated without special education or related services, as handicapped. Children with minimal or other problems, but who do not require special services, will continue to receive appropriate Head Start services but these children are not considered as part of the Congressionally mandated enrollment target. For example, the category "speech impairment" states that "conditions of a transitional nature consequent to the early developmental processes of the child" are not to be considered as a handicap.

Some of the children with severe handicaps have been referred from other agencies to Head Start so that they can participate in a mainstream developmental environment. This opportunity for severely and substantially handicapped children to learn and play with nonhandicapped children is vital to their optimal development.

Not all handicapped children are best served in Head Start programs. Certain severely handicapped children (e.g., the profoundly retarded) require intensive special services on a one-to-one basis which often cannot be provided in a mainstream setting, with nonhandicapped children. Severely handicapped children are enrolled in Head Start except when the professional diagnostic resource recommends that the placement would be detrimental to the child.

5. Services for the Handicapped Child - Head Start grantees and delegate agencies must ensure that all handicapped children enrolled in the program receive the full range of comprehensive services available to nonhandicapped Head Start children, including provision for participation in regular classroom activities. These services--education, social services, parent involvement and health services (including medical, dental, mental health and nutrition)--should consider the child's needs, his or her developmental potential and family circumstances. In addition, special education services and support services are provided to meet the unique needs of the individual handicapped child.

6. Mainstreaming - Since its beginning in 1965, Head Start has maintained a policy of open enrollment for all eligible children, including handicapped children. As was noted in the Head Start Manual of September 1967, "Head Start encourages the inclusion of mentally or physically handicapped preschool children in an integrated setting with other Head Start children." The legislative requirement that a specific portion of the enrollment opportunities be available to handicapped children is consistent with Head Start's approach of serving handicapped children in a mainstream setting. This mainstream experience of learning and playing with nonhandicapped children helps foster a positive self-image and assists the handicapped child in enhancing his or her potential.

7. Program Models - Head Start programs are encouraged to consider several program models and to select the one best suited to meeting the individual needs of children. These program options, which include the standard five day center-based model, variations in center attendance, double sessions, a home-based model, and locally designed options, allow the flexibility necessary to individualize services to handicapped

children and their families. Within each model, Head Start programs are encouraged to develop an individual service plan based on a professional's diagnosis and, with input from parents and the teacher, to respond to the child's unique needs and capabilities.

8. Collaboration with Other Agencies - As part of the effort to strengthen and expand services to handicapped children, Head Start programs are required to make every effort to work with other programs and agencies serving handicapped children in order to mobilize and maximize the available resources and services. Interagency collaborative efforts have been undertaken in the areas of outreach, recruitment, identification and referral assistance; screening, assessment and diagnosis; provision of treatment and support services; and training and technical assistance. Local Head Start programs are required to take affirmative action to seek the support and involvement of other agencies on behalf of handicapped children.

   Local Head Start programs are encouraged to participate in the implementation of P.L. 94-142, the Education for All Handicapped Children Act of 1975. Head Start personnel have been working with local education agencies to ensure that the number of children who have been professionally diagnosed as handicapped and who are receiving Head Start services are included in the State "Child Count" on which allocation of Federal education for handicapped funds is based. Head Start programs are also working with Statewide "Child Find" efforts in the search for unserved handicapped children. Some Head Start programs are reimbursed by local school systems for providing services to preschool handicapped children under the Education for All Handicapped Children Act of 1975 and by other State and local funding auspices. Head Start actively pursues such arrangements.

9. Ten Percent Handicapped Enrollment by State - Head Start's objective is to achieve at least a 10 percent level of enrollment of handicapped children in each State and to provide the special education and related services necessary to meet the children's needs. ACYF Regional Offices work with individual Head Start grantees to help assure this objective. Regional Office staff help grantees to determine enrollment targets, to strengthen recruitment strategies, to develop plans for providing services, and to conduct liaison activities with other community resources.

CHAPTER 2

Status of Handicapped Children in Head Start

Section 640(d) of the Head Start Act requires that "the Secretary shall report to the Congress at least annually on the status of handicapped children in Head Start programs, including the number of children being served, their handicapping conditions, and the services being provided such children."

The data contained in this report were obtained through the Handicapped Services section of the Project Head Start 1983-1984 Annual Program Information Report (PIR). The PIR data are collected for ACYF by The MAXIMA Corporation. The Program Information Report was mailed to all Head Start grantees and delegate agencies in May 1984. Head Start programs reported on the status of handicapped children as of June 15, 1984, or the end of their program year.

The data in this report are based on responses from 1,767 Head Start full year programs. All but one questionnaire mailed to Head Start programs was completed and returned. Therefore, a response rate of almost 100 percent was achieved. Almost all Head Start programs are full year programs that operate eight to twelve months of the year. There are 36 Parent and Child centers (designed to serve children 0 to three years of age and their families) that are not included in the survey.

The questionnaire gathered data in the following categories:

1. General - Number of both handicapped and nonhandicapped children actually enrolled and number of center-based classes operated.

2. Staff - Number of programs with coordinators of services for handicapped children and type of degrees or licenses held, number of volunteers, number of staff provided by outside agencies, and number of programs using PA 26 funds (Head Start funds earmarked for services to handicapped children) for staff.

3. Enrollment of Handicapped Children - Data on number of handicapped children enrolled who were professionally diagnosed (reported by handicapping conditions), levels of special education or related services required, multiple handicaps, referrals from outside Head Start, ages, home-based and center-based experience. Also reported were the number of handicapped children who were located by or referred to Head Start programs that were not able to be enrolled, and the number not yet professionally diagnosed but believed to be handicapped at the time of the survey.

4. Services - Data on number of handicapped children, by handicapping condition, receiving services from Head Start and other agencies; number of programs offering special education and related services for handicapped children and their parents which were provided by Head Start and other agencies; the number of classes with at least one handicapped child enrolled; number of programs reporting utilization of PA 26 funds; and agreements with other agencies to provide needed services to handicapped children.

Data on enrollment of children professionally diagnosed as handicapped, multiply handicapped, levels of special education or related services required, and number of those children receiving services by Head Start and other agencies were reported by handicapping condition.

A. Number of Handicapped Children Enrolled

It has been estimated that there are 258,200 Head Start eligible handicapped children of preschool age (3-5) in the United States.* Although Head Start, with its current enrollment level, cannot meet the needs of all these handicapped children, it is making a notable contribution. A Head Start experience is particularly valuable for those handicapped children who can benefit from a comprehensive developmental experience in a mainstream setting, one that integrates handicapped and nonhandicapped children. The number of handicapped children enrolled in Head Start has increased since the data were first reported in 1973. In November-December 1973, Head Start programs were serving 22,807 handicapped children or 10.1 percent of their enrollment. As of June 1984, Head Start programs reported that they had served 59,335 handicapped children or 12.5 percent of their enrollment during the 1983-1984 program year. Since 1973, the proportion of handicapped children served has ranged from 10.1 percent to 13.4 percent of Head Start enrollment. All but a small fraction of these children are being mainstreamed.

Highlights are:

- o There were 59,335 handicapped children served in Head Start programs in 1984. This represents an increase of 4,431 children over the 54,904 handicapped children served in 1983. Children professionally diagnosed as handicapped accounted for 12.5 percent of total actual enrollment in Head Start programs, a slight increase from the 11.9 percent in 1983.

- o In 49 of the 50 States and the District of Columbia, children professionally diagnosed as handicapped accounted for at least 10 percent of Head Start enrollment.

Head Start has exceeded the 10 percent enrollment level nationally with a 12.5 percent enrollment of handicapped children in program year 1983-1984. Only Alaska, with an 8.8 percent enrollment of handicapped children, fell short of the 10 percent enrollment target.

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* The March 1984 Current Population Survey conducted by the Bureau of the Census reported that the number of children in poverty in the age group 3-5 is 2,582,000. Based on the estimated prevalence of handicapped children in this age group, it is estimated that 10 percent, or 258,200 of these children are handicapped.

In addition, the following territories were below the 10 percent enrollment level: Guam, 9.4 percent; Virgin Islands, 6.4 percent; Trust Territories of the Pacific Islands, 3.4 percent; and American Samoa, 0.4 per cent. (Appendix C provides enrollment data for each State and territory, and Indian and Migrant programs.) All but American Samoa reflect an increase, showing progress toward the 10 percent level.

In the case of the one State and the territories that have less than 10 percent handicapped enrollment, efforts continue to increase the enrollment of handicapped children. The ACYF Regional Offices are working with the Head Start programs in these areas to identify the reasons for the level of enrollment of handicapped children and to devise specific strategies, such as increasing coordination of resources, for expanding enrollment of handicapped children. Progress toward increasing enrollment in these areas will be reported in next year's Annual Report.

Approximately 98.6 percent of the full year Head Start programs served at least one handicapped child. Head Start programs operated centers with 21,982 classes; 80.2 percent of these classes served at least one handicapped child during the 1983-1984 program year.

Approximately 75.6 percent of Head Start programs have enrolled at least 10 percent handicapped children in 1984, reflecting a slight increase over the proportion so reporting in 1983 (71 percent). The proportion of Head Start programs serving at least 10 percent handicapped children steadily increased through 1978 to 76 percent, and has ranged between 67 percent and 73 percent since 1978.

There were 3,867 handicapped children served in the home-based option, a program which uses the home as the central facility and focuses on the parents as the primary factor in the child's development. These children represent 6.5 percent of all handicapped children in Head Start. The vast majority, 89.1 percent of these children (3,449), attended a group experience at least once a month.

Of the 59,335 handicapped children served by Head Start programs, 25.1 percent were 3 years of age or under, 59.5 percent were 4 years old, 14.6 percent were 5 years old, and about 0.9 percent were 6 years or older. (Head Start children 6 years of age or older are in communities where the children go directly from Head Start into first grade, predominantly in the southeastern States.) Data on age of handicapped children enrolled in home-based and center-based options indicate that those in the home-based option are slightly younger as a group; 40.8 percent of the home-based children are 3 years old or younger, while only 24 percent of the center-based children are 3 years old or younger.

Data were collected on the drop out rate for handicapped children for the first time on the 1983-1984 PIR. Of the total number of handicapped children served in Head Start during the 1983-1984 operating year, 5,078 or 8.6 percent dropped out during the operating period. This is a substantially lower proportion than reflected for all children enrolled in Head Start in 1983-1984 where 15.8 percent of the total actual enrollment dropped out during the operating period. Further, of the total number of children who dropped out, 6.7 percent were handicapped children; this is also substantially lower than the proportion of handicapped children of the total actual enrollment (12.5 percent).

B. Types of Handicaps

Head Start is mandated to serve children with a broad range of handicaps such as mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, or other health impaired children, or children with specific learning disabilities who by reason thereof require special education and related services.

The types of handicapping conditions of those children professionally diagnosed as handicapped are presented in Figure 1 and Table 1 as a proportion of the total population of handicapped children in Head Start programs in 1984. Of the handicapped children enrolled in Head Start, 61 percent have been diagnosed as speech impaired. This is by far the largest category of handicapped children served in Head Start programs. The size of this category has been of concern. The State Education Agencies report an even higher proportion of speech impaired children in the preschool age range which they are serving under P.L. 94-142 (see Figures 1 and 2). In addition, Head Start requires that all children be professionally diagnosed and a previously completed study on the speech impaired has determined that most of the children categorized as speech impaired in Head Start had been appropriately diagnosed. Thus, the proportion of speech impaired children served by Head Start is consistent with the proportion of preschool children in the larger population served under P.L. 94-142 by the public schools.

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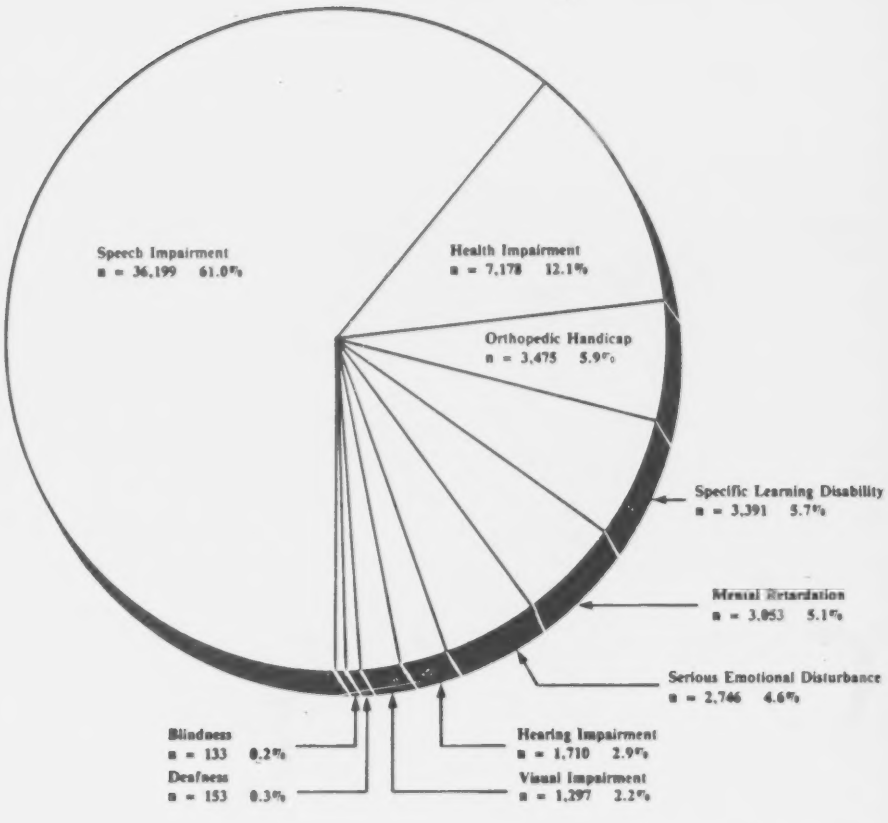
FIGURE 1

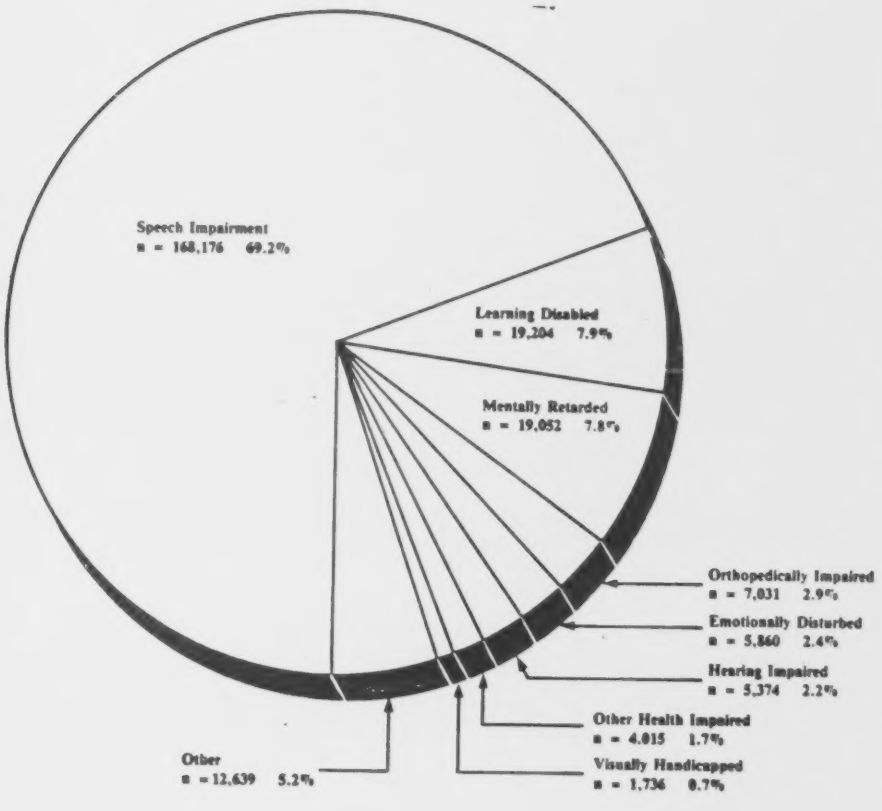
Primary or Most Disabling Handicapping Condition
of Handicapped Children Enrolled in Full Year Head Start
June 1984



(Total Number 59,335)

FIGURE 2

Diagnostic Category of Handicapped Children
Ages 3-5 Served Under P.L. 94-142 as Reported by
State Education Agencies
December 1983



(Total Number 243,087)

Source: Data from the Office of Special Education, U.S. Department of Education. The data were reported by State Education Agencies as Child Count figures for 3-5 year old children served.

Note: The Visually Handicapped category includes blind children. Hearing Impaired includes deaf children; and Other includes deaf-blind and multiple handicapped children.

TABLE I

Types of Handicapping Conditions of Children Professionally Diagnosed as Handicapped

Handicapping Condition	Number	Percent of Total Number Of Children Professionally Diagnosed as Handicapped
Speech Impairment	36,199	61.0
Health Impairment	7,178	12.1
Physical Handicap (Orthopedic)	3,475	5.9
Specific Learning Disability	3,391	5.7
Mental Retardation	3,053	5.1
Serious Emotional Disturbance	2,746	4.6
Hearing Impairment	1,710	2.9
Visual Impairment	1,297	2.2
Deafness	153	0.3
Blindness	133	0.2
TOTAL	59,335	100.0

Head Start programs have enrolled children with a wide range of handicapping conditions. Ninety-six and three-tenths percent of the programs enrolled at least one child who was speech impaired; 67.6 percent of the programs enrolled at least one child whose primary handicapping condition was health impairment; for physical handicap, the proportion was 62.6 percent; mental retardation, 48.3 percent; specific learning disability, 44.5 percent; serious emotional disturbance, 44.1 percent; hearing impairment, 37.6 percent; visual impairment, 34.9 percent; deafness, 6.5 percent; and blindness, 6.5 percent.

There were 36,199 speech impaired children enrolled in Head Start programs. The data on the specific conditions of speech impairment are presented in Table 2.

TABLE 2

Specific Handicapping Conditions of Children
Professionally Diagnosed as Speech Impaired

Specific Conditions	Percent of Total
Expressive or Receptive Language Disorders	51.6
Severe Articulation Difficulties	40.6
Severe Stuttering	2.1
Voice Disorders	1.5
Cleft Palate, Cleft Lip	1.5
Other Speech Disorders	2.7
TOTAL	100.0

There were 7,178 health impaired children enrolled in Head Start programs. The data on the specific conditions of health impairment are presented in Table 3.

TABLE 3

Specific Handicapping Conditions of Children
Professionally Diagnosed as Health Impaired

Specific Conditions	Percent of Total
Respiratory Disorders	18.7
Epilepsy/Convulsive Disorders	16.7
Blood Disorders (e.g., Sickle Cell Disease, Hemophilia, Leukemia)	11.2
Severe Allergies	10.1
Heart/Cardiac Disorders	9.1
Neurological Disorders	6.2
Diabetes	1.6
Autism	1.5
Other Health Disorders	24.9
TOTAL	100.0

There were 3,475 physically handicapped children enrolled in Head Start programs. The data on the specific conditions of physically handicapped are presented in Table 4.

TABLE 4

Specific Handicapping Conditions of Children
Professionally Diagnosed as Physically Handicapped
(Orthopedically Handicapped)

Specific Conditions	Percent of Total
Cerebral Palsy	30.5
Congenital Anomalies	16.0
Deformed Limb	10.1
Bone Defect	9.9
Spina Bifida	6.9
Oro/Facial Malformation	3.6
Absence of Limb	2.4
Severe Scoliosis	1.8
Arthritis	1.4
Other	17.4
TOTAL	100.0

There were 3,391 specific learning disabled children enrolled in Head Start programs. The data on the specific conditions of specific learning disabled are presented in Table 5.

TABLE 5

Specific Handicapping Conditions of Children
Professionally Diagnosed as Specific Learning Disabled

Specific Conditions	Percent of Total
Motor Handicaps	24.8
Sequencing and Memory	20.3
Perceptual Handicap	19.7
Hyperkinetic Behavior	12.9
Minimal Brain Dysfunction	7.0
Developmental Aphasia	5.2
Dyslexia	0.5
Other	9.6
TOTAL	100.0

C. Severity of Handicaps

Head Start serves a significant proportion of children with severe or multiple handicaps. Such children present additional challenges to Head Start staff in the planning and provision of individualized plans. Head Start policy requires that the individual plan of action for special education, treatment, and related services be based on the child's specific handicapping condition(s) and the unique needs arising from those conditions. A child with multiple handicaps is likely to need a variety of treatments and services. Head Start staff, in conjunction with other professionals and the child's family, have to set priorities and objectives, and tailor services for that child in order to provide a focused, systematic plan of action.

In 1984, 10,230 (17.2 percent) of the handicapped children enrolled in Head Start programs had multiple handicapping conditions. Although the proportion is a decrease over the previous year, this is an increase in the number of multiply handicapped children reported last year (10,104). The proportion of multiply handicapped children declined from 27.7 percent in 1978.

Compared to other handicapping conditions, deaf children (73.2 percent) and mentally retarded children (66.4 percent), show the highest incidence of multiple handicap, and speech impaired children the lowest (6.5 percent). Table 6 provides specific data by primary handicapping condition on the number of children who have multiple handicapping conditions.

TABLE 6

Distribution of Number of Multiply Handicapped Children
by Primary or Most Disabling Handicap

Primary Handicapping Condition	Number of Children Reported	Number of Children With One or More Other Handicapping Conditions	Percent of Children Who Have One or More Other Conditions
Deafness	153	112	73.2
Mental Retardation	3,053	2,026	66.4
Blindness	133	61	45.9
Hearing Impairment	1,710	692	40.5
Specific Learning Disability	3,391	1,354	39.9
Physical Handicap	3,475	1,221	35.1
Serious Emotional Disturbance	2,746	751	27.3
Visual Impairment	1,297	300	23.1
Health Impairment	7,178	1,367	19.0
Speech Impairment	36,199	2,346	6.5
TOTAL	59,335	10,230	17.2

Finally, 18.5 percent of the handicapped children served required almost constant special education or related services, 51.5 percent a fair amount, and 30 percent little or some of these services. Compared to last year, those children requiring almost constant special education or related services increased 1.2 percent from 17.3 percent while those requiring a fair amount and little or some services reflected slight decreases of less than one percent. As in the previous years, deaf, blind, mentally retarded, and seriously emotionally disturbed children required the highest levels of almost constant services.

ACYF continues to pursue an active outreach and recruitment effort for enrolling and serving severely handicapped children. The performance standards and revised guidance on services to handicapped children encourage sharing resources and joint enrollment with other programs and agreements between Head Start programs and local education agencies. Additional materials have been developed for use by the Resource Access Projects in training programs to work with more severely handicapped children.

CHAPTER 3

Services to Handicapped Children

In program year 1983-1984, local Head Start programs developed and carried out activities and services of direct and immediate benefit to handicapped children. These activities and services started with active recruitment of handicapped children who might benefit from Head Start, particularly more severely handicapped children. Programs provided assessment and diagnosis to evaluate accurately the nature and severity of each child's handicap in order to serve the child most effectively. Head Start programs continued to increase their own resources and other capabilities to meet the needs of the handicapped children enrolled. In addition, the programs used other agencies as sources of special services. This chapter reports on the degree to which these activities and services are being performed, and utilization of staff, facilities, and materials.

A. Outreach and Recruitment

The data regarding outreach and recruitment were collected specifically on efforts to enroll and serve more severely handicapped children. In previous years, programs reported on special efforts and outreach and recruitment activities utilized to recruit handicapped children in general. Of the Head Start programs, 95.1 percent reported steps taken to enroll and serve more severely handicapped children. The most frequent steps taken by programs reporting these data were: coordination with other agencies serving severely handicapped children (87.1 percent), specific outreach and recruitment procedures aimed at severely handicapped children (68.6 percent), and sharing services with other agencies serving severely handicapped children (61.1 percent). Programs also reported that they held orientation sessions for local diagnosticians and provided them with special materials, etc. (35.1 percent), made change(s) in recruitment and enrollment criteria (23.8 percent), and took other steps (10.4 percent).

Head Start programs and other agencies serving handicapped children have come to recognize the roles of each in providing services. Generally, the Head Start program serves as the primary provider of a mainstreamed learning experience, while other agencies provide the needed special services.

Fifty-two percent of all Head Start programs reported that they were not able to enroll 5,511 handicapped children located by or referred to them. In 1983, 53 percent of the programs reported that they were not able to enroll some handicapped children. Table 7 provides data on the number and percent of such programs, the number of handicapped children, and indicates the primary reason why they were not able to enroll these children. Most common among these reasons were: the children did not fit the age requirements, other agencies serve these children, no available openings, and child's parents refused.

TABLE 7

Rank Ordering By Number and Percent of Programs of Reported Reasons Why Some Handicapped Children Located by or Referred to Head Start Programs Were Not Enrolled

Primary Reasons* for Not Enrolling Some Handicapped Children	Number of Programs	Percent of the 919 Reporting Programs	Number of Handicapped Children Not Enrolled
Did not fit age requirements	362	39.4	954
No available openings	329	35.8	1,373
Other agencies serve these children**	305	33.2	770
Child's parents refused	281	30.6	581
Did not meet income guidelines	232	25.2	706
Handicap too severe for child to benefit from Head Start	190	20.7	324
Lack of adequate transportation	174	18.9	386
Other	152	16.5	417

B. Diagnosis and Assessment of Handicapped Children

The Head Start statutory definition of handicapped children excludes from reporting as handicapped those children with correctable conditions who do not need special services, or children who will not require services additional to those which Head Start programs regularly provide.

In order to meet the legislated requirement for reporting and, more importantly, to ensure that children who are considered handicapped are not mislabeled or misdiagnosed, and to identify the requested special education and related services, Head Start requires that each child reported as handicapped be diagnosed by appropriate professionals. At the time of data collection, all of the 59,335 children reported as handicapped had been diagnosed by qualified professionals. Of these children, 20.7 percent were referred to Head Start by other agencies or individuals and diagnosed prior to Head Start. Another 22.3 percent were similarly referred, but diagnosed after Head Start enrollment. This is a total of 43 percent who were referred to Head Start by other agencies or individuals outside Head Start and is comparable to those so reported in 1983 (42.7 percent).

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* Head Start programs could report more than one primary reason as they report on the primary reason for each of the handicapped children located by or referred to them that they were not able to enroll.

** Head Start programs do, however, serve children who are also served by other agencies when this would lead to the full provision of comprehensive services for the child.

Almost half (48.8 percent) of the total handicapped children were diagnosed between the time of enrollment in Head Start and January 31, 1984. Over one-third (34.3 percent) were diagnosed prior to enrollment in Head Start, and 16.9 percent between February 1, 1984 and the end of the operating period for the programs. Additionally, there were 11,665 children who had been referred by Head Start programs for diagnosis but had not yet been professionally diagnosed. These children, believed to be handicapped, represent 2.5 percent of the actual enrollment in Head Start.

In some communities, the Head Start program was the only channel of diagnosis for preschool handicapped children; in others, the Head Start program supplemented existing diagnostic services. In some situations, the diagnoses were provided by professional diagnostic teams and/or individual professionals, employed as Head Start staff or consultants. In other situations, Head Start purchased needed services from private or public sources.

Head Start programs are encouraged to work with other agencies and private diagnostic providers and to use the following strategy for each child suspected of being handicapped:

Step 1: An interdisciplinary diagnostic team (or an appropriate professional qualified to diagnose the specific handicap) makes both a categorical diagnosis and a functional assessment. Head Start diagnostic criteria (see Appendix A) are used to make a categorical diagnosis. The categorical diagnosis is used primarily for reporting purposes and for overall program planning. The categorical diagnosis is consistent with procedures Head Start programs must follow to ensure confidentiality and to guard against mislabeling. No individual child is identified publicly as "handicapped." Only the aggregate numbers of children with specific handicapping conditions are reported by local Head Start programs to the ACYF.

Step 2: The diagnostic team also develops a functional assessment of the child. The functional assessment is a developmental profile that describes what the child can and cannot do and identifies areas that require special education and related services. The primary purpose of diagnosis is the functional assessment. The parents and child's teacher should be active participants in the functional assessment and contributors to the diagnostic file.

Step 3: An Individual Program Plan (IPP) or an Individual Education Plan (IEP) is developed based on the functional assessment, and becomes part of the diagnostic file. The plan reflects the child's participation in the full range of Head Start comprehensive services and describes the special education and related services needed to respond to the child's handicap. The plan spells out activities that take place in the classroom, involvement of parents, and special services provided by Head Start or other agencies. The plan is developed in concert with the diagnostic team, the parents, and the child's teacher.

Step 4: Ongoing assessment of the child's program is made by the Head Start teacher, the parents, and, as needed, by the diagnostic team. The Individual Program Plan and the delivery of services are modified based on this periodic evaluation.

Step 5: The Head Start program makes appropriate arrangements for continuity of services when the child leaves the program. This may include: (1) updating the assessment information with the development of recommendations for future treatment; (2) conducting an exit interview with parents, schools, and other agencies describing the services rendered to and needed by the child; and (3) transferring of files, with parental consent. The public school is the primary agency responsible for following up to ensure continuity of services after the child leaves the Head Start program.

Staff interchange between Head Start programs and outside diagnostic providers to form a combined diagnostic team, with close and continuing involvement of parents, appears to be the best way to ensure that the above strategy of diagnosis and assessment is implemented. Because many Head Start programs do not have all of the necessary staff expertise in this area, a working relationship with various other diagnostic providers in the community facilitates a comprehensive approach to assessment.

C. Mainstreaming and Special Services

In mainstreaming handicapped children before the age of five, Head Start has built on accepted principles of the importance of the early years in all aspects of a child's development. All children share the same basic needs for love, acceptance, praise, and a feeling of self-worth. All developmental early childhood programs address themselves to the child's individual strengths, weaknesses, mode of learning, and special problems. Head Start attempts to meet these needs through a carefully sequenced educational component and a network of supporting services--medical, dental, nutritional, mental health, social services, and parent participation--tailored to the specific capabilities of each child. In addition, handicapped children are to receive special education, therapy, or other services, either within the Head Start program or as provided by other agencies. Parents of these handicapped children also receive training, counseling, and support services.

Mainstreaming - By functioning in an integrated group during the early years, the handicapped child can learn the ways of the world and some of the problems to be faced. Being with nonhandicapped children at an early age can make the inevitable adjustments of the handicapped child easier. As a result of these experiences, the child will begin to develop a sense of control over his or her own life and an ability to function among other people in spite of the disability.

Preschool programs where handicapped children are mainstreamed give disabled children a chance to play and learn with children who will someday be their co-workers, friends, and neighbors. Both groups benefit most from being together on a regular basis during the years when their attitudes and perceptions of themselves and others are most pliable. The nonhandicapped child will gain a greater understanding of the range of human differences, and will learn to enjoy being with other children who manifest different characteristics and capabilities.

A two year evaluation of mainstreaming in Head Start, conducted for ACYF,* indicated that mainstreaming in Head Start has been generally successful and has included nearly all handicapped children in Head Start. The study established that high levels of time spent in a mainstreaming situation were positively related to developmental gains and increased positive social interaction by Head Start handicapped children.

ACYF has initiated a followup evaluation of the effects of mainstreaming handicapped children in Head Start. The purpose of this study is to follow the children and parents who participated in the former two year study to determine what happens to these children as they progress through public and non-public educational systems. This study will provide longitudinal data on children's receipt of special education and related services during the school years 1977-1984. Results from this followup study are expected to be available soon.

Mainstreaming is in the best interests of a large proportion of handicapped children. There are, of course, some children who, at least initially, may do better in a home-based program. For example, some children may have initial difficulty in adjusting to a center-based Head Start experience. A home-based option can provide the necessary bridge between the family and the nonhandicapped peer group. Others benefit from a flexible approach and may spend part of the week in a special program and part in a mainstream program. Head Start policy requires that the handicapped child be placed in a mainstream classroom setting as soon as appropriate.

Head Start continues to be the largest program that includes preschool handicapped children in group experiences with non-handicapped children on a systematic basis. In 1984, 98.6 percent of the Head Start programs had enrolled at least one handicapped child. Moreover, the data showed that handicapped children were present in 79.9 percent of the Head Start classrooms in 1984. These levels are generally comparable to 1982, and 1983.

Special Services - Handicapped children have special needs which require special services. They may also require special equipment, materials, or modification of existing facilities. The special services required may be provided through Head Start or through outside agencies, or through a combination of both. Table 8 reports comparative levels for special services provided to handicapped children and their parents in 1982, 1983, and 1984, by reporting Head Start programs.

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* Applied Management Sciences (AMS), an independent research firm, completed their evaluation of mainstreaming in Head Start in February of 1979. The AMS evaluation reports are available through the Educational Resources Information Center (ERIC) System. These reports are available for purchase from Computer Microfilm International Corp., ERIC Document Reproduction Service, P.O. Box 190, Arlington, Virginia 22210 (Telephone: 703-841-1212). The order numbers are ED 168-236 through 240, ED 168-291, ED 176-433, and ED 177-803.

TABLE 8

Three Year Comparison of Special Services
Provided to Handicapped Children Enrolled in
Full Year Reporting Head Start Programs

Services Provided	1982	1983	1984
Total number of children who are receiving special education or related services from Head Start staff	47,092	51,697	55,416
Total number of children who are receiving special services from other agencies	33,449	36,664	38,280
Total number of parents receiving special services from Head Start related to their child's handicap	35,726	39,217	43,756

In each category of special services, the trend of increased numbers of children receiving special services continues. The number of children receiving special education or related services from Head Start staff increased by 7.2 percent from 51,697 in 1983 to 55,416 in 1984. The total number of children receiving special services from other agencies increased 4.4 percent from 1983 to 1984. The number of parents receiving special services from Head Start increased by 11.6 percent from 39,217 in 1983 to 43,756 in 1984. This increase more than doubles the number of parents served in 1977.

About 93.4 percent of the handicapped children received special education or related services from Head Start staff and 64.5 percent received special services from other agencies. About 59 percent of the handicapped children received services from both sources, reflecting a small decrease compared with 61.9 percent so reported in 1983. Over one-third (34.4 percent) received services from Head Start staff only, and 5.5 percent from other agencies only. Only 1.1 percent of the children received no special education or related services. This figure is higher than the 1983 figure of 0.9 percent and lower than that of 1.5 percent for 1982.

Special Services Provided by Head Start

Head Start programs provide many special education and related services to handicapped children. These services include individualized instruction, counseling for parents, and psychological and physical therapy.

The special education or related services provided by Head Start staff, listed in order of the proportion of programs providing the services, are: individualized teaching techniques (93.4 percent); speech therapy and language stimulation (83.2 percent); transportation (79 percent); education in diet, food, health, and nutrition (78.5 percent); counseling for parent or family (77.6 percent); assistance in obtaining special services included in the IEP/IPP (74.6 percent); special teaching equipment (66.4 percent); psychotherapy, counseling and behavior management (58.2 percent); medical or psychological diagnosis, evaluation, or testing (48.2 percent); medical treatment (40.2 percent); special equipment for children (37.7 percent); physical therapy and physiotherapy (16.2 percent); occupational therapy (12.8 percent); and other services (5.6 percent).

Special Services Provided by Other Agencies

Head Start also received services for handicapped children in their programs from other agencies. These services, listed in order by the proportion of programs receiving services, are: medical or psychological diagnosis, evaluation or testing (84.6 percent); speech therapy and language stimulation (80.8 percent); medical treatment (73.3 percent); family or parental counseling (69.5 percent); psychotherapy, counseling and behavior management (65.3 percent); individualized teaching techniques (63.3 percent); assistance in obtaining special services included in IEP/IPP (62.3 percent); special equipment for children (51.2 percent); physical therapy (49.6 percent); education in diet, food, health, and nutrition (40.1 percent); transportation (38.1 percent); occupational therapy (34.7 percent); special teaching equipment (45.3 percent); and other services (4 percent).

Special Services Provided to Parents of Handicapped Children

Of the Head Start programs serving handicapped children, 93.2 percent provided special services to parents of handicapped children. The services, listed in order of percent of programs providing the services, are: referrals to other agencies (86.4 percent); counseling (80.3 percent); conferences with technical staff and other meetings (77.8 percent); literature or special teaching equipment (75.4 percent); transportation (72.8 percent); visits to homes, hospitals, etc. (72.3 percent); parent meetings (69.1 percent); medical assistance in securing medical services (65.9 percent); workshops on school services (56.4 percent); special classes (40.2 percent); and other services (8.3 percent).

Other Special Services Provided by Head Start

In 1984, 96.4 percent of the Head Start programs had a coordinator of services for handicapped children. In 1984, 34.6 percent of the programs reported a full time coordinator as compared to 41.3 percent in 1983. About half (50.3 percent) reported a part time coordinator and 16.6 percent indicated that as a delegate agency they were served by a handicapped coordinator at the grantee level. Of the 1,767 programs in 1984, 83.5 percent had a coordinator with a degree or license. In 19.5 percent, the coordinator's degree or license was in early childhood/special education, in 18.3 percent, it was in special education, 10.9 percent in speech pathology/audiology, 12.2 percent in psychology, and 53.8 percent in some other area.

PA 26 funds are monies earmarked by the Head Start Bureau for use by grantees for services to handicapped children. In 1984, PA 26 funds were used by 38.8 percent of the programs to pay for full or part time teaching staff, 82.7 percent for full or part time specialists or consultants, and 7.6 percent for special modifications in physical facilities. Programs also reported purchasing or leasing various types of materials or equipment. These included 70.2 percent of the programs securing instructional materials, 61.8 percent screening/diagnostic tests, 35.1 percent special play equipment, 10.6 percent special transportation equipment, and 19.2 percent other materials and equipment. Almost 9.5 percent of the programs did not indicate utilization of PA 26 funds in any of these areas.

In 1984, 9,403 volunteers in over 41 percent of the Head Start programs provided special assistance to handicapped children. This is an increase over the 9,340 volunteers reported in 1983 programs. In addition, 6,404 staff members that provided special assistance to handicapped children in 59 percent of the Head Start Programs were from other agencies. This is a slight increase from 1983 when 6,062 staff from outside agencies in over 55.6 percent of the programs provided special assistance.

Resource Access Projects (RAPS) - Head Start's commitment to individualization for all children, including those with handicaps, has provided the basis for mainstreaming handicapped children in a setting with non-handicapped youngsters.

Head Start's effort to serve handicapped children, including the severely handicapped, has placed an increased responsibility on grantees to locate and provide specialized services and staff training. In support of the Head Start mainstreaming movement, the Head Start Bureau of ACYF established a network of fifteen Resource Access Projects (RAPs) to serve a designated number of Head Start programs in each ACYF region throughout the nation. The fifteen RAPs are also providing services to Migrant grantees. A sixteenth RAP was funded in 1984 to serve Indian grantees in ten western States.

It is the responsibility of each RAP to assist Head Start in working with handicapped children. Activities performed by each RAP include the following:

- o Identify local, regional and national resources;
- o Determine local Head Start needs and match these needs with available resources;
- o Coordinate the delivery of services to Head Start programs;
- o Provide training and technical assistance;
- o Promote and facilitate collaborative efforts between Head Start and other agencies; and
- o Provide resource materials to Head Start grantees.

Additionally, the RAPs have responsibility for providing training designed to introduce the eight resource manuals in the series Mainstreaming Preschoolers* which focus on mainstreaming in Head Start and spell out techniques that can be used by teachers and parents in working with handicapped children. The RAPs are responsible for conducting a minimum of one workshop per State each year, and have been designated as the primary mechanism for dissemination of the Mainstreaming Preschoolers series.

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* For the information of those working in programs for handicapped children, the series of eight program manuals detailing the procedures and techniques for mainstreaming handicapped preschoolers into Head Start classrooms is for sale by the Government Printing Office. Requests should be addressed to: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. Orders must be accompanied by a check or money order made payable to the Superintendent of Documents. The orders must also include titles and GPO stock numbers. The documents that are available are Mainstreaming Preschoolers: Children With Mental Retardation (GPO Stock No. 017-092-00029-4), $6.50; Mainstreaming Preschoolers: Children With Visual Handicaps (GPO Stock No. 017-092-00030-8), $6.00; Mainstreaming Preschoolers: Children With Health Impairments (GPO Stock No. 017-092-00031-6), $6.50; Mainstreaming Preschoolers: Children With Hearing Impairments (GPO Stock No. 017-092-00032-4), $6.50; Mainstreaming Preschoolers: Children With Speech and Language Impairments (GPO Stock No. 017-092-00033-2), $6.50; Mainstreaming Preschoolers: Children With Orthopedic Handicaps (GPO Stock No. 017-092-00034-1), $6.50; Mainstreaming Preschoolers: Children With Learning Disabilities (GPO Stock No. 017-092-00035-9), $6.50; Mainstreaming Preschoolers: Children With Emotional Disturbances (GPO Stock No. 017-092-00036-7), $6.50.

In 1983-1984, the RAPs conducted mainstreaming training for 15,415 persons including teachers, teacher aides, and other personnel. A separate contract was awarded to evaluate the mainstreaming training. In a sample of 288 Head Start programs contacted by the contractor evaluating the RAPs, it was found that 33 percent of the Head Start teachers had received mainstreaming training during 1983-1984. Evaluations by participants have shown that these conferences were very successful. Teachers and other Head Start staff members, including aides, directors, parents, and support staff, have indicated that they have benefited greatly from the training. Ninety-six percent of the trainees who completed evaluation forms gave the RAPs the top two ratings on the scale used to evaluate training. Further, from the sample of 288 programs, Head Start programs indicated that training was the most valuable service provided by RAPs. Participants indicated they learned new skills for working with handicapped children and learned to work more comfortably with handicapped children. They anticipated that they would do three or four things differently as a result of training (e.g., closer observation of handicapped children, use new materials and resources to work with handicapped children in the classroom, etc.).

The RAP training and the Mainstreaming Preschoolers manuals have been widely acclaimed not only throughout the Head Start community, but have also achieved recognition far beyond the Head Start programs for which they were primarily intended. The manuals have been sent to other Federal agencies, national professional associations, volunteer organizations that provide services to handicapped children, and State educational agencies. They are also being used in public schools, day care programs, universities and other organizations. The series has been shared with foreign governments as well.

Other major foci of the sixteen RAPs include promoting collaboration between Head Start and other programs and agencies serving handicapped children, and facilitating the inclusion of Head Start in the State plans for serving handicapped children, required under P.L. 94-142. In 1974, an interagency agreement between ACYF and the Office of Special Education in the Department of Education designated the RAPs as liaisons between Head Start and the State Education Agencies (SEAs). The RAPs have been facilitating the participation of Head Start grantees in the development of the State plans for preschool handicapped children which are required under P.L. 94-142. Formal collaborative agreements describing how Head Start and SEAs will coordinate services to preschool handicapped children are now in place in 40 States or territories. Four new written agreements and one reconfirmation of a previous written agreement were signed during the 1983-1984 program year, three of them were between ACYF and SEAs. One of the agreements was between the Head Start grantee and the public schools.

Some key points from these four new written agreements are provided as examples:

- In Georgia, Head Start programs will participate with local education agencies (LEAs) in conducting ongoing Child Find activities; Head Start and LEAs are to develop joint screening procedures, participate in training sponsored by either and may jointly fund activities for staff training. Head Start personnel are to be invited to attend IEP/Placement meetings for handicapped children entering LEA programs and LEAs, through a designated liaison, are to assist Head Start programs in conducting follow-up for handicapped children and families transferring to LEAs.

- In the District of Columbia, Head Start is recognized as an appropriate placement for handicapped children; Head Start and the public schools agree to dual enrollment whenever possible and appropriate and agree to mutually shared training and technical assistance services for personnel. Head Start will orient the child and family to the public school system to ensure the smooth transition from Head Start to public school.

- In Oregon, Head Start programs will follow the SEA guidelines for diagnostic criteria and definitions and still address the diagnostic categories identified by Head Start. The SEA will, upon request, participate in Head Start in-service programs, and provide Department special education publications and technical assistance. ACYF agrees to monitor Head Start for compliance with P.L. 94-142 and both agree to assign at least one staff person responsible for coordinating the development of interagency programs, providing leadership and facilitating communications. The agreement provides for an annual meeting to review and update the provisions.

- In Alaska, when the LEA considers Head Start to be the appropriate placement, Head Start is to be involved in the IEP process and it is recommended that Head Start be involved in the annual IEP review meetings. LEAs are responsible for providing transportation to children with handicapping conditions if stipulated as a related service in the child's IEP, and it is recommended that transportation services be agreed upon by LEAs and Head Start and included in the IEP. LEAs have responsibility for assuring that all handicapped children are identified by appropriate screening, assessment and diagnostic procedures; Head Start is responsible for initial screening of Head Start children and it is recommended that LEAs assist Head Start with screening procedures when necessary; the LEA is responsible for assessment and diagnosis of children who have been referred and the Head Start director's participation is encouraged. The SEA and Head Start also encourage the development of local cooperative agreements and the RAP provides technical assistance and materials relating to cooperative agreements.

On September 23, 1983, the U.S. Department of Health and Human Services, Office of Human Development Services and the U.S. Department of Education, Office of Special Education and Rehabilitation Services, signed an Interagency Agreement for a $400,000 project to improve services to young handicapped children. Funding for the project was provided by the Department of Education, Special Education Programs ($300,000) and the Department of Health and Human Services, Administration for Children, Youth, and Families ($100,000), with collaboration from the Administration on Developmental Disabilities. The major goal of the project was to expand a training program being developed by Head Start to prevent abuse and neglect of young handicapped children. Copies were disseminated to Head Start programs in 1984 and a version adapted for use by public schools and other agencies is being developed for distribution in 1985. With the collaboration of public

school personnel this prevention program also included handicapped kindergarten children. The RAPs and University Affiliated Facilities programs in five geographic areas developed and field tested the materials in Head Start and public schools. Copies of these materials will be disseminated in 1985. This agreement also provides for the development of a film on serving a severely handicapped child within a Head Start program and during the transition to a public school. This film was produced in 1984 and training materials to accompany it will be completed during 1985.

In November 1983, ACYF funded the Deferred Diagnosis Pilot Project to be implemented by the New England RAP and Region VII RAP in Connecticut and Iowa respectively. The project was funded as part of an overall effort to review the diagnostic criteria for reporting handicapped children in Head Start. Deferred diagnosis was defined by ACYF for purposes of this study as "the deferment of the final, definitive diagnosis of handicapped children for a specified period of time and under specified circumstances." Both pilot projects, working through an Advisory Committee, developed diagnostic criteria, implemented the concept in selected sites in Connecticut and Iowa, and assessed the results of the project.

In Connecticut, staff concluded that the pilot project clearly demonstrated the usefulness of deferred diagnosis as a category for handicapped children served in Head Start. The Advisory Committee felt that the next step should be to test the category more broadly and that the dual underpinnings for the guidelines developed for the category--measurable delay documented by an interdisciplinary diagnostic process and follow-up activities designed to broaden and clarify the diagnostic picture--represented sound clinical practice which should not be diluted. They also felt that the standards set for this category were valid for all young handicapped children and hoped to see the guidelines developed serve as a model for the development of guidelines describing both criteria and follow-up activities for each diagnostic category. They were troubled both by the frequency of reported emotional disturbance in the sample children and by the high incidence of stressful home situations or parental disability.

In Iowa, administrative circumstances limited the scope of the pilot. However, the project staff concluded from the information gathered that there is a small percentage of handicapped preschool children who are difficult to diagnose and who do not fit neatly into the current diagnostic categories used by Head Start. They believed it is helpful to have a longer period to observe the child and analyze the problem areas closely without delaying the services which appear to be the most appropriate.

Results of this pilot project were also taken into consideration by the RAP Task Force in their analysis of the Diagnostic Criteria for Reporting Handicapped Children in Head Start.

The list of sixteen RAPs in the network is provided in Appendix B.

D. Coordination With Other Agencies

Current Local Efforts - Head Start programs reported working with other agencies in several ways. Of the 59,335 handicapped children enrolled in the programs, 25,472 (43 percent) had been referred to Head Start by other agencies or individuals, including welfare departments, public school systems, Easter Seal Societies, and Crippled Children Associations. Of those referred, 12,260 (48.1 percent) were professionally diagnosed as handicapped prior to enrollment in Head Start.

Nearly 65 percent of the handicapped children in Head Start received special education or related services from other agencies. These services included speech therapy, language stimulation, physical therapy, and other therapy related to the child's specific handicapping condition, special health services, special equipment for the child, and family counseling. About 59 percent of the programs utilized 6,404 additional staff from outside agencies to provide special assistance for handicapped children.

About 96 percent of the programs reported having written or informal agreements with LEAs or other agencies regarding services for handicapped children. A total of 1,492 Head Start programs (84.4 percent) had a written or informal agreement with LEAs regarding services to be provided to handicapped children in Head Start. A total of 1,562 (88.4 percent) of the Head Start programs had written or informal agreements with agencies other than LEAs regarding services to be provided to handicapped children in Head Start.

APPENDIX A

Diagnostic Criteria for Reporting
Handicapped Children in Head Start

All children reported in the following categories* must have been diagnosed by the appropriate professionals who work with children with these conditions and have certification and/or licensure to make these diagnoses. These professionals must take into consideration the cultural/ethnic characteristics of the Head Start children.

To be counted as handicapped, children must meet two criteria. They must have one of the following handicapping conditions (by professional diagnosis) and, by reason thereof, require special education and related services.

Blindness - A child shall be reported as blind when any one of the following exists: (a) the child is sightless or has such limited vision that he/she must rely on hearing and touch as his/her chief means of learning; (b) a determination of legal blindness in the State of residence has been made; (c) central acuity does not exceed 20/200 in the better eye, with correcting lenses, or whose visual acuity is greater than 20/200, but is accompanied by a limitation in the field of vision such that the widest diameter of the visual field subtends an angle of no greater than 20 degrees.

Visual Impairment (Handicap) - A child shall be reported as visually impaired if central acuity, with corrective lenses, does not exceed 20/70 in either eye, but who is not blind; or whose visual acuity is greater than 20/70, but is accompanied by a limitation in the field of vision such that the widest diameter of visual field subtends an angle of no greater than 140 degrees or who suffers any other loss of visual function that will restrict learning processes, e.g., faulty muscular action. Not to be included in this category are persons whose vision with eyeglasses is normal or nearly so.

Deafness - A child shall be reported as deaf when any one of the following exists: (a) his/her hearing is extremely defective so as to be essentially nonfunctional for the ordinary purposes of life; (b) hearing loss is greater than 92 decibels (ANSI 1969) in the better ear; (c) legal determination of deafness has been made in the State of residence.

Hearing Impairment (Handicap) - A child shall be reported as hearing impaired when any one of the following exists: (a) the child has slightly to severely defective hearing, as determined by his/her ability to use residual hearing in daily life, sometimes with the use of a hearing aid; (b) the child has hearing loss from 26-92 decibels (ANSI 1969) in the better ear.

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* Multiple Handicaps: Children will be reported as having multiple handicaps when, in addition to their primary or most disabling handicap, one or more other handicapping conditions are present.

Physical Handicap (Orthopedic Handicap) - A child shall be reported as crippled or with an orthopedic handicap who has a condition which prohibits or impedes normal development of gross or fine motor abilities. Such functioning is impaired as a result of conditions associated with congenital anomalies, accidents, or diseases; these conditions include, for example, spina bifida, loss of or deformed limbs, burns which cause contractures, and cerebral palsy.

Speech Impairment (Communication Disorder) - A child shall be reported as speech impaired with such identifiable disorders as receptive and/or expressive language impairment, stuttering, chronic voice disorders, and serious articulation problems affecting social, emotional and/or educational achievement; and speech and language disorders accompanying conditions of hearing loss, cleft palate, cerebral palsy, mental retardation, emotional disturbance, multiple handicapping conditions, and other sensory and health impairments. This category excludes conditions of a transitional nature consequent to the early developmental processes of the child.

Health Impairment - These impairments refer to illness of a chronic nature or with prolonged convalescence including, but not limited to, epilepsy, severe asthma, severe cardiac conditions, severe allergies, blood disorders (e.g., sickle cell disease, hemophilia, leukemia), diabetes, neurological disorders, or autism.

Mental Retardation - A child shall be considered mentally retarded who, during the early developmental period, exhibits significant sub-average intellectual functioning accompanied by impairment in adaptive behavior. In any determination of intellectual functioning using standardized tests that lack adequate norms for all racial/ethnic groups at the preschool age, adequate consideration should be given to cultural influences as well as age and developmental level (i.e., finding of a low I.Q. is never by itself sufficient to make the diagnosis of mental retardation).

Serious Emotional Disturbance - A child shall be considered seriously emotionally disturbed who is identified by professionally qualified personnel (psychologist or psychiatrist) as requiring special services. This definition would include, but not be limited to, the following conditions: dangerously aggressive towards others, self-destructive, severely withdrawn and noncommunicative, hyperactive to the extent that it affects adaptive behavior, severely anxious, depressed or phobic, or psychotic.

Specific Learning Disabilities - These disabilities refer to a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations. Such disorders include such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Not included are learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental disadvantage. For preschool children, precursor functions to understanding and using language, spoken or written, and computational or reasoning abilities are included. (Professionals considered qualified to make this diagnosis are physicians and psychologists with evidence of special training in the diagnosis of learning disabilities and special educators with at least Master's degrees and evidence of special training in the diagnosis of learning disabilities.)

APPENDIX B

1983-1984 Resource Access Project Network

DHHS Region	States Served	Resource Access Project (RAP)
I	Connecticut Maine Massachusetts New Hampshire Rhode Island Vermont	Education Development Center, Inc. 55 Chapel Street Newton, Massachusetts 02160
II	New Jersey New York Puerto Rico Virgin Islands	New York University School of Continuing Education 3 Washington Square Village, Suite 1M New York, New York 10012
III	Delaware District of Columbia Maryland Pennsylvania Virginia West Virginia	Georgetown University Child Development Center 3800 Reservoir Road, NW Bles Building Washington, D.C. 20007
IV	Florida Georgia North Carolina South Carolina	Chapel Hill Training-Outreach Project Lincoln Center, Merritt Mill Road Chapel Hill, North Carolina 27514
	Mississippi	Friends of Children Head Start 119 Mayes Street Jackson, Mississippi 39213
	Alabama Kentucky Tennessee	Peabody College/Vanderbilt University Box 317 Nashville, Tennessee 37203
V	Illinois Indiana Ohio	University of Illinois Colonel Wolfe School 403 East Healey Champaign, Illinois 61820
	Michigan Minnesota Wisconsin	Portage Project 626 East Slifer Street Portage, Wisconsin 53901

DHHS Region	States Served	Resource Access Project (RAP)
VI	Arkansas Louisiana New Mexico Oklahoma Texas	Texas Tech University Special Projects Division P.O. Box 4170 Lubbock, Texas 79409
VII	Iowa Kansas Missouri Nebraska	University of Kansas Medical Center Children's Rehabilitation Unit 26 Kansas City, Kansas 66103
VIII	Colorado Montana North Dakota South Dakota Utah Wyoming	Denver Research Institute/SSRE University of Denver Denver, Colorado 80208
IX	Arizona California Nevada	Child, Youth and Family Services 1741 Silverlake Boulevard Los Angeles, California 90026
	Pacific Trust Territories and Hawaii	University of Hawaii Biomedical Building, C-105M 1960 East West Road Honolulu, Hawaii 96822
X	Idaho Oregon Washington	Portland State University Division of Continuing Education P.O. Box 1491 Portland, Oregon 97207
	Alaska	Easter Seal Society of Alaska 620 East 10th Avenue, Suite 203 Anchorage, Alaska 99501
American Indian Programs in:		
	Arizona Colorado Montana Nevada New Mexico North Dakota Oklahoma South Dakota Utah Wyoming	American Indian Law Center, Inc. P.O. Box 4456 - Station A Albuquerque, New Mexico 87196

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APPENDIX C

Survey Results of Handicapped Children in Head Start by State*
(or Geographical Entity)

Full Year 1983-1984

State (or Geographical Entity)	Number of Grantees and Delegate Agencies Responding	Total Number of Children Enrolled**	Number of Children Professionally Diagnosed as Handicapped Through End of Operating Year***	Percent of Enrollment Professionally Diagnosed as Handicapped Through End of Operating Year
Alabama	38	10,972	1,261	11.49
Alaska	3	809	71	8.78
Arizona	18	3,464	383	11.06
Arkansas	21	6,215	805	12.95
California	117	37,548	3,913	10.42
Colorado	24	5,710	780	13.66
Connecticut	27	4,911	539	10.98
Delaware	4	760	145	19.08
District of Columbia	4	1,997	234	11.72
Florida	35	13,185	1,570	11.91
Georgia	39	10,525	1,343	12.76
Hawaii	4	1,348	163	12.09
Idaho	8	1,174	290	24.70
Illinois	79	27,135	2,972	10.95
Indiana	34	6,802	949	13.95

* State data exclude Migrant and Indian Programs.

** These enrollment data reflect total actual enrollment as obtained from item 12 B1f of the Project Head Start 1983-1984 Annual Program Information Report (PIR).

*** The data on the Head Start Handicapped Efforts were obtained as part of the PIR and were collected as of June 15, 1984 or the end of the operating year.

APPENDIX C (continued)

Survey Results of Handicapped Children in Head Start by State*
(or Geographical Entity)

Full Year 1983-1984

State (or Geographical Entity)	Number of Grantees and Delegate Agencies Responding	Total Number of Children Enrolled**	Number of Children Professionally Diagnosed as Handicapped Through End of Operating Year***	Percent of Enrollment Professionally Diagnosed as Handicapped Through End of Operating Year
Iowa	22	3,539	609	17.21
Kansas	21	3,420	526	15.38
Kentucky	47	10,928	1,293	11.83
Louisiana	40	10,182	1,217	11.95
Maine	13	1,858	1,357	19.21
Maryland	28	5,325	827	15.53
Massachusetts	32	8,579	1,240	14.45
Michigan	87	22,912	2,580	11.26
Minnesota	26	5,177	652	12.59
Mississippi	22	29,738	3,255	10.95
Missouri	22	9,554	1,477	15.46
Montana	9	1,186	155	13.07
Nebraska	14	1,946	359	18.45
Nevada	4	537	104	19.37
New Hampshire	6	766	126	16.45
New Jersey	32	10,555	1,286	12.18

* State data exclude Migrant and Indian Programs.

** These enrollment data reflect total actual enrollment as obtained from item 12 B1f of the Project Head Start 1983-1984 Annual Program Information Report (PIR).

*** The data on the Head Start Handicapped Efforts were obtained as part of the PIR and were collected as of June 15, 1984 or the end of the operating year.

APPENDIX C (continued)

Survey Results of Handicapped Children in Head Start by State*
(or Geographical Entity)

Full Year 1983-1984

State (or Geographical Entity)	Number of Grantees and Delegate Agencies Responding	Total Number of Children Enrolled**	Number of Children Professionally Diagnosed as Handicapped Through End of Operating Year***	Percent of Enrollment Professionally Diagnosed as Handicapped Through End of Operating Year
New Mexico	23	3,998	425	10.63
New York	152	28,915	3,335	11.53
North Carolina	43	11,693	1,521	13.01
North Dakota	7	657	104	15.83
Ohio	75	23,198	3,152	13.59
Oklahoma	25	8,087	1,252	15.48
Oregon	18	3,005	520	17.30
Pennsylvania	61	16,610	2,559	15.41
Rhode Island	8	1,571	220	14.00
South Carolina	18	6,652	783	11.77
South Dakota	7	1,024	158	15.43
Tennessee	24	9,408	1,286	13.67
Texas	91	22,716	2,531	11.14
Utah	10	1,947	257	13.20
Vermont	6	859	133	15.48

* State data exclude Migrant and Indian Programs.

** These enrollment data reflect total actual enrollment as obtained from item 12 B11 of the Project Head Start 1983-1984 Annual Program Information Report (PIR).

*** The data on the Head Start Handicapped Efforts were obtained as part of the PIR and were collected as of June 15, 1984 or the end of the operating year.

APPENDIX C (continued)

Survey Results of Handicapped Children in Head Start by State*
(or Geographical Entity)

Full Year 1983-1984

State (or Geographical Entity)	Number of Grantees and Delegate Agencies Responding	Total Number of Children Enrolled**	Number of Children Professionally Diagnosed as Handicapped Through End of Operating Year***	Percent of Enrollment Professionally Diagnosed as Handicapped Through End of Operating Year
Virginia	30	5,129	836	16.30
Washington	26	4,312	643	14.91
West Virginia	26	4,166	703	16.87
Wisconsin	34	6,800	822	12.09
Wyoming	5	799	109	13.64
American Samoa	1	1,800	8	0.44
Guam	1	394	37	9.39
Puerto Rico	29	15,731	1,723	10.95
Trust Territories of The Pacific Islands****	6	1,984	167	8.42
Virgin Islands	1	1,180	76	6.44
State Subtotal	1,607	441,392	54,841	12.42
Indian Programs	94	15,855	1,818	11.47
Migrant Programs	66	18,681	2,676	14.32
Total	1,767	475,928	59,335	12.50

* State data exclude Migrant and Indian Programs.

** These enrollment data reflect total actual enrollment, as obtained from item 12 B1f of the Project Head Start 1983-1984 Annual Program Information Report (PIR).

*** The data on the Head Start Handicapped Efforts were obtained as part of the PIR and were collected as of June 15, 1984 or the end of the operating year.

**** Include Head Start programs in the Commonwealth of Northern Mariana Islands, Marshall Islands, Palau, Ponape, Truk, and Yap.

EXECUTIVE SUMMARY

STRENGTHENING HEAD START FAMILIES: REDUCING HIGH RISK THROUGH MENTAL HEALTH PREVENTION/INTERVENTION (MHP/IP)

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EXECUTIVE SUMMARY

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EXECUTIVE SUMMARY

Introduction

This Executive Summary will present, analyze, and discuss the findings of the final report from the mental health demonstration and research project entitled,"Strengthening Head Start Families: Reducing High Risk Through Mental Health Prevention/Intervention" (referred to as the MHP/IP [Mental Health Prevention/Intervention Project] throughout the remainder of this report). The project was submitted to and funded by the U.S. Department of Health and Human Services/Coordinated Discretionary Funds Program for fiscal year 1984/1985. The Latin American Civic Association (LACA) was the recepient of this 14 month grant which covered the period from August 1984 to September 1985. LACA, a non-profit organization, is one of the largest Head Start delegate agencies in the state of California and currently serves 960 children and families at 23 sites, 64 classes, and has a staff of 192 people. The MHP/IP was staffed with a licensed mental health specialist, 5 counselors, and a research team.

The concept of prevention, which was integral to the MHP/IP, has 3 levels of action. As stated by Leavell and Clark, "In public health terminology, prevention is an all embracing concept having three distinct levels: primary prevention, referring to actions taken prior to the onset of disease to intercept its causation or to modify its course before man is involved; secondary prevention meaning early diagnosis and treatment; and tertiary prevention, indicating rehabilitative efforts to reduce the residual effects of illness (Goldston, 1977:19)."

The MHP/IP assessed the effectiveness and proposed a model of mental health treatment service delivery to a high risk Head Start population. Three preventive mental health interventions were tested: 1) staff training and consultation, 2) parent education and involvement, and 3) in-house mental health treatment services, including short-term psychotherapy.

The first intervention, staff training and consultation, was designed as a primary prevention strategy to provide services to teaching and service component staff on the implementation of mental health skills to increase their job effectiveness. The second intervention, parent education and involvement was also designed as a primary prevention strategy to provide training and needed skills to support parents as the primary educators of their children, as well as to empower parents to participate in Head Start activities, and in the lives of their children and families. The third intervention, in-house mental health treatment services, including short-term psychotherapy, provided secondary prevention, early identification, and intervention of children and families with problems, as well as encouraged prompt referral to mental health and/or appropriate components. The counseling staff provided in-house short-term psychotherapy which offered the opportunity to reduce social or psychological dysfunctions which had the potential to produce long-range damaging effects.

The research aspect of this study was carried out through the utilization of a series of instruments which enabled the reseachers to collect three types of data. The first type of data collected was through the implementation of a needs assessment and follow-up. The needs assessment was designed to provide information regarding the needs, social history, and special circumstances

impacting upon the child and family. Information regarding problems of high risk and utilization of human services provided an understanding of the systems about which families are aware. The needs assessment was administered to 960 families participating in LACA's Head Start program. The final returns yielded a sample population of 845 completed interviews.

The follow-up assessment, implemented with a sample of 220 families, provided baseline comparisons with the needs assessment population. More importantly, the document provided data on any changes encountered by the family during the year in Head Start. A second type of data collected by the researchers was provided by the Family Social Competence Survey. The MHP/IP wanted to identify factors associated with the social competence of the family which would assist in early identification and early intervention. By focusing on the strengths of families, this survey underscored the need for human service professionals to work with families as partners. A third type of data was obtained on 199 children and families who received treatment from the mental health component. The documents provided data on demographics, treatment and outcome evaluations on individual cases, and was gathered from counselors, teachers and parents.

Another important aspect of the MHP/IP was the utilization of the ecological model with its broader base over the less effective deficit models. In the MHP/IP, the child and family were viewed from a holistic systems orientation. A multi-vectored ecological model of treatment was used combining biological, psychological, social, and environmental factors. In essence, the MHP/IP focused on working with family strengths not deficits; that is, parents were seen as partners with program staff working together to enhance child and family development.

The ecological model addresses the whole person: the internal and external factors which comprise an orientation to the interrelatedness of one's self and one's environment. Deficit models, on the other hand, tend to assume low-income families are poor because of a set of social and psychological conditions which keep them at these levels. Although these models gained influence during the War on Poverty, critics have established that deficit models "blame the victim" for their problems and do not address the inegalitarian structures of society which helped to foster these conditions. Instead, the MHP/IP proposed to view a person from a multi-vectored ecological perspective.

The primary goal of Head Start is the promotion of social competence. To date, approximately 80% of the Head Start population are enrolled in center-based programs with a primary focus on a cognitive oriented education in which program components serve the education component. 20% of the population are enrolled in home-based family oriented programs.

The MHP/IP proposed a shift from a program which has primarily emphasized cognitive development to a program which focused on the promotion of social competence in Head Start children and family, and where all the components including the education component, serve the Head Start child and family. When viewed from an ecological perspective, this basic premise assumes the child is not a cognitive entity alone but an individual with a physical body, a social and emotional essence, and must be viewed as an integral being who interdependently relates to his family, community and society.

To date, there have been few research studies undertaken to show the effects of mental health service delivery in Head Start programs. A report, Head Start in the 80's (HHS, 1980) recommended a shift from a child-centered to a family-centered program. The effectiveness of the proposed MHP/IP model, which is in keeping with this recommended shift, portends that for education and human service delivery on a national level, the child no longer be viewed in isolation from the family. Rather, the family should be considered as an integrated unit.

The potential for prevention and treatment services in the area of mental health for Head Start children and families has been recognized as critical. Research shows that 10-25% of Head Start children were thought to suffer from serious developmental and psychiatric disturbances (Cohen, Solnit, Wohlford, 1979). The theory of prevention asserts that through early identification and intervention the high incidence of severe problems and the potential for long-range damaging effects will be reduced. And yet, no model for prevention, identification and intervention has been demonstrated as an effective strategy for mental health service delivery to a Head Start population. The MHP/IP proposes to provide a model for prevention, early identification, and intervention which can be adapted, replicated, and become the state of the art for mental health in Head Start, and provide a model for national change in the educational system.

The Executive Summary presents findings related to the three preventive mental health intervention strategies:

- o staff training and consultation to increase job effectiveness on implementing mental health skills;
- o parent education and involvement to support parents in their role as the primary educators of their children;
- o in-house mental health treatment services which include short-term psychotherapy, prevention, early identification and intervention for children and families with problems.

The following sections of this Executive Summary describe the background and methodology for the MHP/IP, followed by a presentation of the major findings. The final section is a discussion of the program and policy implications of the project findings.

BACKGROUND

The Objectives of Head Start

To understand the origins of Head Start, one must also consider the times in which it came about: the civil rights struggles for social and political justice, the War on Poverty, social intervention strategies for the poor and disadvantaged, and a renewed interest in the role of the environment in human development (Zigler and Valentine, 1979:3). It was a time when the need to prepare children to succeed in school gave Head Start its impetus. Utilizing existing evidence, early planners suggested that a large scale

intervention had to include cognitive approaches, parent involvement, medical needs, and nutritional activities (Cooke, 1979:xxiv). This work produced seven original goals which would guide Head Start (Richmond, Stipek, Zigler, 1979:137):

1. Improving the child's physical health and physical abilities;

2. Helping the emotional and social development of the child by encouraging self-confidence, spontaniety, curiosity, and self-discipline;

3. Improving the child's mental processes and skills, with particular attention to conceptual and verbal skills;

4. Establishing patterns and expectations of success for the child that will create a climate of confidence for future learning efforts;

5. Increasing the child's capacity to relate positively to family members and others while at the same time strengthening the family's ability to relate positively to the child and his problems;

6. Developing in the child and his family a responsible attitude toward society, and encouraging society to work with the poor in solving their problems; and

7. Increasing the sense of dignity and self-worth within the child and his family.

Head Start had five original components which suggested an ideological direction, which would counteract the culture of poverty view that physical and mental health was directly linked to the circle of poverty and poor educational achievement:

1. Medical and dental services for poor children;

2. Social services for the child's home environment and family, since home and family were considered responsible for low educational achievement, family intervention was seen as logical;

3. Psychological services which emphasized staff consultation and community consultation rather than testing and clinical activities, as well as help develop parent involvement and community participation;

4. School readiness programs that emphasized preparing the child to enter school on equal terms with other children; and

5. Volunteer services which would enable parents to participate fully in Head Start programs (Spring, 1976:222).

Beyond Deficit Models of Social Policy

The use of deficit models such as the culture of poverty have been very influential in formulating social policy. Yet, despite the continued influence of these models on policy, social scientists (Baratz and Baratz, 1970; Leacock, 1971; Ryan, 1976) have criticized these models for methodological reasons such as neglecting the cultural patterns of the poor as a means of finding solutions to their conditions. Stipek, Valentine and Zigler (1979) write: "It seems evident now that preschool intervention with the disadvantaged cannot be expected to contribute to the elimination of poverty, since poverty in America has its roots in other, noneducational aspects of American society (p. 480)."

Recently, a new perspective has arisen which calls for a shift in policy and with it, a new perspective towards children and families. The call is for policies which counteract conditions that affect the family's ability to cope with their environment; a call for policies which go beyond deficit models. Bronfenbrenner and Weiss (1983) suggest the concept of the ecology of human development defined as the "scientific study of the progressive, mutual accommodation between the developing person and the changing properties of the immediate and broader contexts in which the person lives (p. 393)."

A report published by the U.S. Department of Health and Human Services (1980) suggests a shift from a child-centered approach widely used in Head Start to a family-centered approach. To date, this has been a theoretical shift which has not been actualized in programming. For one thing, many of the child-centered programs which still exist originated in the maternal and child study groups developed during the progressive era of American education in the 1920's and 1930's (Cremin, 1964, Lightfoot, 1978; Button and Provenzo, 1983). Based on the ecology of human development, the findings found in this summary represent a sound step in the development and delivery of comprehensive mental health services to children and families in Head Start. The MHP/IP proposed a comprehensive model for mental health service delivery, relying on all Head Start components for its success and most importantly, saw the role of parents as a major aspect in its contribution to strengthening child and family competence.

Development and Practice of Mental Health in Head Start

Since 1965 Head Start has grown into the largest comprehensive child development program in the United States. There have been great variations among regions of the country, differences in the interests and style of local program administration, and varying concerns of Head Start directors. In spite of variation, the national Head Start program could be said to have placed its greatest emphasis on the preschool child's achievement of lasting intellectual skills throughly early cognitive oriented education. In comparison, there has been little explicit attention given to the child's emotional development and psychological difficulties. Head Start has undergone a variety of changes over the years, but of all the components, what was originally known as psychological services and now known as mental health, has been the least visible, least adequately funded and least valued (Cohen, et.al., 1979).

For the most part, the mental health components in Head Start receive referrals on children in the program and then refer them to outside agencies. However, research has shown this low income population will rarely use available community mental health services. The reasons include their belief the family should be able to manage its own affairs, their distrust of bureaucracy, and for the increasing number of ethnic minorities, the lack of bilingual and culturally sensitive counselors (Barrera, 1978). Mental health services to children, families and minorities typically receive the lowest priority in funding (Childrens Defense Fund, 1982). Low income families and their children experience more stress and therefore, a greater potential for high risk in health and mental health disorders than the typical population of preschool age children and their families. The President's Commission on Mental Health (1978) indicates extensive evidence has led to the conclusion poverty increases the risk for serious psychiatric and developmental disturbances. Almost any disorder - schizophrenia, alcohol and drug addiction, retardation, depression, epilepsy, severe learning disturbance and delinquency - is more likely to occur with a high risk population. Research also shows 10-25% of Head Start children were thought to suffer from serious developmental and psychiatric disturbances. Cohen, et.al., (1979) indicates that:

> The consensus among clinicians was that if many of these Head Start children were seen in private practice consultation and were from middle-class families, serious developmental and psychiatric disturbances would be diagnosed. Did the symptoms and signs of developmental delay and irregularity have a different meaning in the offspring of the poor (p.206)?

It is estimated that two million of the three million seriously emotionally disturbed children (66%) in this country do not get the mental health service they need (Children's Defense Fund, 1982). This figure does not even begin to take into account the children who are beginning to show signs of emotional problems.

The main goal of Head Start is, according to Zigler and Valentine (1979), to increase social competence in children of low-income families. The performance standards state the goals and objectives for the Head Start program and provide a set of guidelines for service delivery. However, the goals and objectives of these standards have been interpreted in a number of ways. As stated, Head Start has focused primarily on a cognitive approach, thus there has been little understanding and, therefore, implementation of the original goals of the Head Start program. In addition, there has been little comprehension of the goals of mental health in Head Start for reasons which include stigmas attached to mental health, educationally oriented administrators; and, after 20 years of Head Start, there have been only two mental health professionals responsible for mental health at the National Head Start Bureau for less than 5 years. Cohen et. al., (1979) writes, for example:

> The extent of the undervaluation of psychological expertise can be brought out most dramatically by comparison with the educational component. For example, throughout its history, Head Start was heavily engaged in the development of

> preschool curricula. Large sums were spent on writing new curricula, implementing them, and evaluating their short and long-term cognitive effectiveness. In this process, educators were central to the Head Start program at all levels. In contrast, Head Start administrators showed relative apathy toward the special knowledge of mental health professionals working with families in improving children's self-esteem, in detecting emotional difficulties, in altering communal values, in treating sick children, and in other potentially critical aspects of relevant concern (p. 278).

Since accountability has not been built into the system towards quality programming, for the most part agencies have run maintenance mental health programs in order to meet compliance. It has been observed by the authors that within Head Start, one person usually supervises two or more components (i.e., one person may supervise social services, handicap, and mental health). In fact, the authors have consistently observed, in these cases, that mental health has been the component which has received the least attention. In 1985, as a typical example, one agency serving over 800 children reported having a $60,000 dollar dental budget, a $62,000 dollar handicap budget, and a $5,000 dollar mental health budget.

According to current federal guidelines, Head Start can either hire a mental health professional or a mental health coordinator (para-professional). Usually both of these people contract with mental health consultants who are the direct providers of mental health services to children and families. However, in-house psychotherapy is rarely provided. The authors have found for the most part, the services given have not met the needs of this high risk population due to the following:

1. Head Start has attracted consultants who many times have lacked experience with Head Start, preschool children, families, minorities, and high risk populations;

2. Consultants have generally lacked an ongoing relationship and involvement in the overall Head Start program and have provided minimal hours of services;

3. There has generally been little accountability built into the system for quality services and follow-through. Therefore, insufficient, and ineffective service delivery have resulted;

4. Mental health staff has generally not had the needed bilingual language capabilities and cultural sensitivity, to serve the growing number of non-English speaking populations.

Latin American Civic Association's Mental Health Program Development, Treatment Ideology and Service Delivery

In the MHP/IP, the child and family were viewed from a multi-vectored ecological model of treatment combining biological, psychological, social and environmental factors in order to adequately address the cause of a problem. For example, if a child were referred to mental health for

aggressive behavior, the counselor assessed if there were biological or organic factors precipitating the aggression. The psychological well being of the child, the siblings and the parents were evaluated in assessing the problem; and the social structure, extended family, cultural and societal pressures were also assessed to see how they affected the child ard the family.

Parents were viewed as the primary educators of their children. Family strengths and problems were viewed from the standpoint of cause and effect. In focusing on the child alone (who usually manifested the effect and/or symptom of the family dynamics), the origin of the problem rarely was resolved. One of the program's objectives was to show that as parents underwent changes, those changes directly affected the children and entire family. This point underscored the need for a shift from a child centered program to a family centered approach. In addition, the MHP/IP provided staff training and consultation to increase teacher's skills in fostering an emotionally healthy and supportive classroom environment. Focus was also placed on promoting positive attitudes toward mental health, and shifting the existing focus in mental health from pathology to health and wellness. Counselors were employed who were bilingual and culturally sensitive to their client's needs.

The MHP/IP provided a model for prevention, early identification, and intervention. In this study, the goal of primary prevention was to enhance parent-child-teacher interactions, both in the classroom and in the home. The provision of parent education, the use of volunteer parents as part of the mental health component, and an increase in the utilization of helping services by Head Start family members were used as a means of directing parents, and therefore their children, toward improved social competence in the enhancement of their own lives.

Secondary prevention occurred through early diagnosis and treatment. During the early months of the program, all 960 children received a 4 hour observation in each classroom followed by a 2 hour training and consultation with the teaching staff. The mental health counselor and the Child Development Specialist (CDS) did a joint supervision/observation cycle. The result was early identification of children with problems and prompt referral to mental health and/or appropriate components. As a result, children were referred to the program for services including in-house short-term psychotherapy with their families. Counseling staff provided early intervention which offered the opportunity to identify and reduce social or psychological dysfunctions which traditionally have not been addressed on this level.

Referrals were initiated by the teaching staff, parents or support staff. If the referral were on a child, a mental health counselor consulted with the teacher, observed the child in the classroom, conducted a parent/teacher conference to discuss the problem and to explain the mental health services and process. A preliminary session with the parents alone, followed by a screening session with the entire family took place. Any adjunctive services, needed to evaluate the problem were also provided at that time, (i.e., medical evaluation, referral to handicap services, and/or appropriate components). The case was then staffed and recommendations were made for treatment. An interpretive session was held with the parents and a decision was jointly reached as to the course of treatment. Family, conjoint, play, and individual adult therapy were provided. A plan was

made to train the teacher and support the child in the classroom. Eight weeks after the case was closed a final review was conducted to evaluate the status of the case and determine whether the results of therapy were successful or whether additional treatment was needed.

Tertiary prevention indicates rehabilitation efforts to reduce the residual effects of illness. Children who needed long-term intervention were referred to handicap services. The mental health and the handicap components coordinated service delivery to these children and families. Those families that are thought to benefit from continued therapy were encouraged to do so and are referred to the appropriate agencies.

A mental health program that serviced a mainstream population could emphasize primary prevention. A mental health program that services primarily a high risk population must go beyond tradition. If only traditional preschool programs were offered to high risk populations, then the children would not have a "head start" in the educational system and in lives. Concurrently, if a traditional mental health program that emphasizes primary prevention were offered, there would be no remediation offered to the severe problems our population is faced with. Head Start provides a short-term, one year intervention into the lives of high risk children to prepare them for the educational system and their lives. This is what a mental health prevention program should do.

MHP/IP Emphasis On Social Competence

Head Start's performance standards state that social competence is the primary goal of Head Start. Due to Head Start being primarily focused on a cognitive approach, no clear definition and operationalization of social competence as an effective way of measuring the gains of Head Start in children have been explored (Zigler and Trickett, 1977).

An effort of the MHP/IP was to define social competence and develop measures to assess the social competence of children and families. The MHP/IP's overall goal for social competence was to strengthen child, and family self esteem, individual responsibility, personal integrity, creativity, interdependence, an individual's everyday effectiveness in dealing with the environment, and a concern for the whole. The project focused on strengthening the family's life and supporting the relationships between the child, the family, the Head Start program and the community. In addition, the second aspect of social competence, the ability of the child and family to adapt functionally through the acquisition of new skills for living, was also emphasized. The authors believed that by reducing the psychological dysfunction in children and families who were referred to the mental health component, these families would be able to function more adaptively and learn effective problem solving skills. The early identification and treatment of high risk factors, which have the potential to cause long range damaging effects, were believed to allow family members to better interact and respect one another, know the importance of their role in the family, and support their children in everyday experiences.

In addition to promoting social competence by reducing high risk which was partially assessed through the reduction of psychological dysfunctions, the authors wanted to use a pre- and post test and social competence index to

measure the reduction of high risk. However, because of the brevity of the study, these goals were not accomplished within the 14 months of this study. The authors will continue the development of this analysis at a future date.

METHODOLOGY

Procedures

The following were the procedures utilized by the authors in testing the intervention strategies of staff training and consultation, parent education and involvement, and in-house mental health treatment services:

1. Staff Training and Consultation

Goals

The goals for staff training and consultation were: (1) to orient the staff to the implementation of the MHP/IP for the purpose of understanding and supporting the project, knowing their role, understanding the staff training and consultation process, procedures for referrals, and procedures for mental health services; (2) facilitate the staffs positive attitude toward mental health services; (3) promote early identification of children with problems and prompt referral to mental health and or appropriate components; (4) provide direct training to teaching staff in the area of promoting an emotionally supportive environment in the classroom; and (5) provide training to teaching staff in the areas of child growth and development, observation techniques, effective communication, behavior management, and strategies for dealing with specific child behaviors.

Objectives

The objectives for the staff training and consultation were: (1) to increase the utilization of mental health services measured by an increase in the number of referrals received by the mental health component (measured by the number of referrals); (2) to reduce child psychological dysfunction by training the teaching staff on the uses of effective behavior and emotional classroom management skills (measured by Mental Health Individual Child Observation/Action Plan and 8 week review); and (3) to increase the teaching staff's confidence in their abilities to handle their classrooms (measured by teacher feedback to cycles).

Procedures

The following were procedures used for staff training and consultation: (1) MHP/IP staff orientation; (2) Mental Health Classroom Observation/ Supervision Cycle; and (3) Mental Health Individual Child Observation/Action Plan; and (4) Staff Evaluation of Mental Health Services.

2. Parent Education and Involvement

Goals

Parents bring their children to Head Start for assistance in preparing

them for future participation in public education. In this process, parents are introduced to a myriad of services, committees, rules and regulations, and other structural factors which are presented as vehicles in completing their children's "head start". The MHP/IP project developed activities which would enable parents to work as partners with Head Start teachers and staff in achieving the total development of the child and family.

Objectives

The objectives of parent education and involvement activities were to provide training of parents in parenting skills and child development in order to reduce the potential for high risk. In addition, community resources would be mobilized, parent participation increased in order to provide social support and enhance coping mechanisms within Head Start families.

Procedures

There were three original procedures organized as part of the study: 1) parent education sessions; 2) monthly family nights; and 3) parent education/support staff training.

3. In-House Mental Health Treatment Services

The primary goal and objective of treatment services was to provide prevention, early identification and intervention in problems that interfere with a child and/or family's social and psychological development for the purpose of fostering social competence.

Goals

The goals for treatment services were: (1) to strengthen family life and support parents as the primary educators of their children; (2) to promote social competence in the child and family; (3) to support relations between the child, family, Head Start program and community; and (4) to develop a positive attitude towards mental health services.

Objectives

The objectives for treatment services were: (1) To reduce psychological dysfunction in children and families that were referred to the mental component through prevention, early identification and intervention (measured by findings of case summary); (2) To increase utilization of mental health services to the mental health component (measured by the number of referrals received); (3) To switch the focus of mental health service delivery from a child-centered program to a family-centered program (measured by original presenting problem and presenting problem after assessment).

Procedures

Treatment services were in two steps (1) assessment and, (2) treatment/short term psychotherapy.

1. Assessment

The following were the stages of assessment of the problem: (a) mental health classroom observation/supervision cycle; (b) referrals; (c) classroom observation; and (d) parent/teacher conference. All of the children in the program received an initial classroom observation for purposes of early classroom identification and referral to the mental health and/or appropriate component. When a mental health referral was received on a child, a classroom observation was made. This was followed by a parent/teacher conference at which time the parent, teacher, and mental health counselor discussed the problem and were then (parents) scheduled for a preliminary session.

2. Treatment/Short-Term Psychotherapy

The following were stages of treatment/short-term psychotherapy: (a) preliminary session; (b) screening session; (c) staffing/treatment plan; (d) interpretive session; (e) continuation of treatment; (f) case closing; and (g) final review.

At the preliminary session, parents met with the mental health counselor to more intensively discuss the history of the presenting problem, learn about the services, and process of the mental health component. This was followed by a screening session at which time the parents, referred child, siblings, and other members of the household, come together for the initial family session to assess overall family dynamics, parenting responsibilities, communication patterns, alliances, limit setting, etc. Any other needed evaluations were done at the time. The case was then staffed. The entire assessment was taken into account when formulating an appropriate treatment plan. At the interpretive session, the mental health counselor and parents jointly reached a recommendation for treatment. The teaching staff was also trained to assist the child in the classroom. After the case was closed, a final review was conducted eight weeks later to measure the success of treatment. If other problems had arisen, the family could, if necessary, come in for further treatment.

Sampling

The target population for this study were the 960 families who participated in the Head Start program during the 1984-1985 school year. Data from three sample populations are presented based upon the needs assessment, follow-up assessment and reported treatment outcomes. Every family had the potential to participate in the needs assessment survey. All 64 sites were represented in the analysis of the findings. Of the 960 families contacted, 845 surveys were completed and returned.

The follow-up assessment survey utilized a sample of 220 families. Site selection for this follow-up assessment was based on those sites reporting a higher number of referrals to the mental health component. All families and children had the potential to be identified as requiring services. Teachers, parents, and support staff served as the three primary referral sources. 199 mental health referrals were made.

Instrumentation

7 instruments were used for the purpose of analysis. The intent of these instruments was to provide a systematic outcome analysis of the amount and type of social need, and the level of social competence. Outcome measures related to staff training and consultation and mental health services delivered, provided information used to assess the impact of these services. These instruments include 1) Needs Assessment and a Follow-up Assessment; 2) Family Social Competence Survey; 3) Mental Health Classroom Observation/Supervision Cycle; 4) Teacher Feedback on Mental Health Observation/Supervision Cycle; 5) Mental Health Individual Child Observation/Action Plan; 6) Mental Health Intake Form; and 7) Case Summary Form.

DEMOGRAPHICS OF THE POPULATION

Needs Assessment Data

The needs assessment was designed to elicit information on the needs, problems, and status of the children and families participating in Head Start. The instrument reflected four areas of concern to Head Start: 1) family information; 2) the child; 3) family issues; and 4) service utilization. Family information was designed to provide data on the family, such as the type of residence, number of adults and children in the household, whether or not families had friends or family members within the community acting as support systems. Information on the child was elicited from parents on the child's overall health, sleeping and eating habits, and child care outside the home. The section on family issues asked questions regarding the parent's feeling toward themselves such as life satisfaction, problems which present themselves on a daily basis, and the child's reaction to family disagreements. Lastly, the researchers wanted to know the degree to which parents utilized human services, their knowledge of specific agencies, and what type of information or services they felt were needed at the present time.

Demographics

The average age of LACA's Head Start parents was 28 years old. Age groups ranged from 19 years of age to 63 years. It was deduced that parents whose ages ranged in the late 50's or early 60's were not always parents of the Head Start children but legal guardians.

Family and Friends in Community

These questions were concerned with support systems available to family's as a means of coping with problems or concerns to a family. Such systems could mean having someone to care for the child, one who offers advice in certain situations or provides a certain ambiance which enables the family to cope. Of the respondents, 374 or 45% of the population responded they had a few family members. 205 or 25% responded they had many family members, while 249 or 30% answered they did not have any family (see Table 1).

With friends in the community, 493 or 59% responded they had a few friends. 269 or 32% answered they had many friends in the community. 69 or 9% did not have any friends in the community.

Table 1

Presence of Family and Friends in the Community

	Family in Community (N=828)	Friends in Community (N=831)
Present in Community		
Yes, alot	205/25%	269/32%
Yes, a few	374/45%	493/59%
None	249/30%	69/9%

Language

The LACA Head Start program has historically served a large percentage of Spanish speaking people. As indicated by language of preference, this assumption continues to appear true. Of those who responded to this question, 467 or 64% chose to speak only Spanish; 164 or 22% spoke only English; 92 or 12% spoke English and Spanish, and 17 or 2% spoke another language (see Table 2).

Table 2

Language Preference of Head Start Families

N=740

	Frequency	Percentage
Monolingual Spanish	467	64%
English	164	22%
Bilingual English/Spanish	92	12%
Other Languages	17	2%
Total	740	100%

Child Problems

Parents were asked a series of questions regarding their children's overall health. Researchers were concerned with identifying existing problems in order to discover if parents would utilize Head Start's referral system. In general, the questions focused on sleeping and eating habits.

One question that appeared to be constant was a parent's perception of a problem compared to the assessment by a human service professional. Parents, for example, were asked if their children were in good health. Not surprisingly, 798 or 96% of the parents who responded to this question felt their children were, in fact, in good health, 28 or 3% of those who responded felt there was a problem with their child's health, while only 3 individuals chose not to respond.

The research team then asked if children had received a physical exam in the previous twelve months. The data revealed a larger distribution of responses among the population. 63% or 519 of those who responded stated

their children had received a physical exam, 69 or 8% of the parents stated their children were taking one form of medication. This could have been a simple aspirin or prescribed form of medication. Again, it should be noted the researchers were interested in the parent's perception of a child's problem. 752, or 91% were not taking medication while 4 parents chose not to respond.

Follow-up Assessment Comparisons

The findings showed some changes had occurred with the population over the school year. For example, in the needs assessment, the researchers asked if parents participated in a pre-paid health plan. 72% responded they did not, while 27% said they did, 19% did not respond. It was assumed not having prepaid insurance was definitely courting a possible high risk situation (see Walden, Wilensky, Kasper, 1985). This situation did not change over the year. Even the smaller sample of the follow-up assessment showed a high percentage without pre-paid insurance: 89% without insurance as compared with 9% with insurance, 2% did not respond (see table 3).

The health of the child seemed to remain stable according to parent's perceptions. As reported in the need assessment, 96% of the parents reported their children in good health. In the follow-up assessment, 94% of the parents reported their children as being in good health, with 6% of the children not being in good health. Data on whether or not the child had received a physical exam also remained constant. In the needs assessment, 63% of the parents reported their children had received physical exams while in the follow-up assessment, 87% of the children had received physical exams, compared to 37% and 12% respectively who had not. A related finding from the follow-up assessment seemed to confirm the fact children were in good health.

Table 3

Availability of Prepaid Health Insurance

Needs/Follow-up Assessment Comparison

Do you have a Pre-paid Health Plan?	Need Assessment N=804	Follow-up Assessment N=221
Yes	214/27%	20/9%
No	581/72%	197/89%
No Response	9/1%	4/1%

Social Competence Survey

The MHP/IP had as one of its goals the identification of factors associated with the social competence of the family, which would serve to enhance the ability for early identification and intervention with Head Start families. It would also serve to indicate the relative strength of the family in coping with daily life. This was probably the most important reason for

conducting the survey of social competence: To point out the strengths of families underscores the need for human service professionals working with families as partners not as individuals with some cultural deficiency. Thus, the four factors identified by the research team for the survey were: 1) language use and bilingualism, 2) family needs, 3) interest in community affairs, and 4) parent attitudes towards education.

An important aspect of social competence was the degree to which parents were aware of, and utilized, social service agencies. It was assumed that knowledge of and use of these agencies could help to minimize high risk. The researchers provided a list of 10 existing social service agencies. Parents were asked to note if they were aware of any of the agencies on the list and if they were not, could they give the name of a similar agency. Parents were generally not aware of the listed agencies. This brings up important implications since it has been documented how low-income Latino families do not utilize human service agencies. When asked if they had used any of these services, 192 (27%) of the parents said they had, while 515 (73%) said they had not. This response changed dramatically when parents were asked if they would ever use these services. 470 (76%) said they would while 146 (24%) said they would not.

Parents were then asked about specific services they might feel a need for. They could respond in 4 ways: just need the information, have utilized in the past year, need the service now and no need for service. In table 4, there is a listing of the services given to the parents. The majority of respondents indicated there was no need for services which can be interpreted in different ways. For one, these respondents may perceive that internal family problems do not exist which require the services of social service agencies. There may be the belief families should be able to cope with any issue at a given time. It could also be due to a family's perception that stigmas would be attached to them by asking for help from a human service profesional. The next highest group responded with a need to acquire information in order to be aware of available services. These individuals were followed by the group who needed services immediately. Lastly, the smallest group had previously utilized various services.

Table 4

Reported Needs of Head Start Families

	Need Service Information #	Services Utilized In Past Year #	Need for Service Now #	No Need for Service #
Financial Needs (N=553)	46	7	29	471
Spouse Abuse (N=554)	23	6	6	519
Child Abuse (N=554)	26	3	8	517
Alcohol/Drug Abuse (N=554)	27	6	9	512
Psychological Services (N=550)	43	11	21	475
Crisis Intervention (N=551)	56	8	29	468
Medical Needs (N=557)	110	14	58	375
Shelter (N=557)	51	12	37	457
Food (N=555)	84	11	57	403
Clothing (N=554)	76	3	68	407
Family Needs (N=549)	67	11	37	434
Individual Counseling (N=550)	34	15	25	476
D.P.S.S. Problems (N=553)	26	20	23	484
Employment (N=555)	69	10	55	421
Housing Needs (N=550)	90	2	53	405
Legal Assistance (N=548)	53	3	27	465
Immigration (N=549)	76	5	48	420
ESL (N=553)	138	3	72	340
Adult Education (N=553)	104	3	41	405
Vocational Training (N=553)	45	2	26	480
Translation Services (N=553)	25	3	16	509

FINDINGS

Staff Training and Consultation

One of the three preventive mental health strategies of the MHP/IP was staff training and consultation. The literature has indicated that consultation is an important aspect of community mental health programs. In Head Start, consulation can be an effective means of providing training to teachers in promoting the emotional and social development of children. This section presents the findings for staff training and consultation of the 128 teaching staff and includes the following: 1) the Mental Health Classroom Observation/ Supervision Cycle; 2) Teacher Feedback of the Mental Health Classroom Observation Supervision Cycle; 3) the Mental Health Individual Child Observation/Action Plan; and 4) Staff Evaluation of Mental Health Services.

Mental Health Classroom Observation/Supervision Cycle

The Mental Health Classroom Observation/Supervision Cycles took place in each of the 64 classrooms in the first few months of the program. These cycles took an average of 5.5 hours per classroom totaling 352 hours. The mental health staff evaluated teacher performance and classroom environment and rated them on a scale of 1 to 5, 1 being unsatisfactory and 5 excellent. Table 5 shows the results of this evaluation.

According to the following chart, the areas in which the teachers exhibited the highest level of skills (ranking over 50%) in the good/ excellent category were: (1) providing an emotionaily healthy environment; (2) demonstrating consistency and fairness; (3) interacting with the children; and 4) promoting positive child/child interaction. The areas in which the teachers exhibited the lowest level of skills (over 20%) in the unsatisfactory or needs improvement category were: (1) adult/adult interaction; (2) creating a level of positive stimulation in the classroom; (3) nurturing a child's self-esteem; and (4) behavior management. Based on the results of this evaluation, staff training and consultation were provided in the areas of need.

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Table 5
Mental Health Observations of
Teacher Performance and Classroom Environment
N=64 Classrooms

TEACHER'S PERFORMANCE	Unsatisfactory or Needs Improvement	Satisfactory	Good/ Excellent
Behavior Management	20 3%	30.5%	49.14%
Child Support/reinforcement	18.63%	35.59%	45.75%
Interactions with children	8.47%	38.98%	52.53%
Communication Skills	16.94%	37.28%	45.75%
Nurturing child's self esteem	20.32%	32.2%	47.44%
Consistency/fairness	13.54%	32.2%	54.22%
Children's needs appropriately met by teachers	18.63%	38.98%	42.36%
CLASSROOM ENVIRONMENT			
Emotionally healthy/supportive	13.54%	30.5%	55.92%
Level of positive stimulation	22.02%	32.2%	45.75%
Positive Social Interactions child/child	15.24%	33.89%	50.83%
Positive Social Interactions child/adult	15.24%	37.38%	47.45%
Positive Social Interactions adult/adult	40.66%	18.64%	40.67%

Teacher Feedback of the Mental Health Classroom Observation/Supervision Cycle

Following the Mental Health Classroom Observation/Supervision Cycle, the teachers completed the Teacher Feedback form on which they gave their comments on the cycle. Of LACA's 128 teaching staff, 75 (58%) responded. 67 (89%) stated that the cycle was helpful and 8 (11%) said that the cycle was not helpful.

Mental Health Individual Child Observation/Action Plan

When a referral was received, a mental health counselor did a classroom observation of the child. A Mental Health Individual Child/Action Plan was completed and provided the foundation for staff training to provide an emotionally supportive classroom environment. For program year 1984-85, the mental health component received 199 referrals and 168 of these reached the classroom observation stage. With a minimum of 3 hours of observation and

consultation per referral, a total of 504 hours were provided. In addition, the mental health staff provided a minimum of 1½ hours per referral of additional training and consultation to the teaching staff totaling 300 hours. The total number of hours for staff training and consultation are 1,156 hours.

Staff Evaluation of Mental Health Services

The mental health components, like all other components, were evaluated by the teaching staff in the areas of helpful services, services most valued, inappropriate services and lacking or insufficient services. Some of the helpful services from the mental health component were, according to teacher's responses: the providing of classroom management strategies, showing concern for children and families, responding quickly to referrals and involving parents in the problem solving process. Services most valued by teacher's included: the counselors' providing adequate time for talking with teachers about classroom problems, providing help for the special needs of children, and providing training to deal with emotional and behavioral problems. Inappropriate services included: lack of follow-up and inconvenient location for counseling. Finally, lacking of insufficient services included: lack of notice before site visits, need for increased communication between counselors and teachers, and lack of home visits.

Parent Education and Involvement

The purpose of the parent education and involvement activities of the MHP/IP was to support parents as the primary educators of their children and enhance the potential for parents to become involved in LACA's Head Start activities. Traditionally, the focus has been on parent involvement not parent education.

A comprehensive low-cost parent education program was designed by the author's for the MHP/IP which included parent education sessions, family nights, intensive parent education/staff training, and parent support groups. Though the MHP/IP under the mental health component made this initial plan for parent education with the approval of LACA's administration, when it came down to carrying out the actual program, the parent involvement component, with the support of the administration, designed and implemented their own plan for parent education which tended to revert back to the old model of focusing more on involvement rather than on education and involvement. The activities planned and organized by the Parent Involvement Component revolved around family nights and parent education sessions. The Parent Involvement component did not plan and implement these activities with the other components, and as a result, there was low turn-out.

Family Nights

This activity provided a forum for information, education and questions on parenting for family members as well as supervised play activities for children. It was an opportunity for parents to obtain further information to benefit them as the primary educators of their children.

Parent Education Sessions

These sessions were conducted by the parent educator (primary prevention). The sessions were done in clusters where parents from two or three sites met together at one location; the initial training provided one session for each parent cluster. Prior to the parent trainings, all LACA staff (supervisory and support) were given the same training. The objective of such training was to introduce all staff to the quality and content of the program. The expected outcome was broad parent participation in the training, supported by and encouraged by all staff (teachers, social workers, and parent involvement aides etc.)

Another problem held back the overall success of parent education and involvement activities. Parent educators, who were originally scheduled to begin work in November, 1984 were not hired until the end of January, 1985. As a result, training occurred late in the program year and only one session of parent education was provided which hampered the quality of outcome.

In-House Mental Health Treatment Services

This section presents findings for the in-house mental health treatment services of the MHP/IP. Included are: (1) frequency data on demographic information on families; (2) identification of treatment needs; (3) treatment characteristics; and (4) outcome evaluation of mental health treatment services. As previously stated, LACA enrolled 960 children for the program year 1984/85. The mental health component received 199 referrals representing 21% of LACA's population, and of these, 121 received treatment (representing 13% of the population).

Demographic data on the families included the following information: of the families that received treatment, 59% were Mexican/Mexican American, 15% Caucasian, 7% other Hispanic, 5% Black, 3% other, and 11% mixed ethnic backgrounds. 49% of the families referred for mental health services were monolingual Spanish speaking, 32% were monolingual English, 17% were bilingual English/Spanish, and 2% other.

57% of the referred children lived with both biological parents, 26% lived with their biological mother, 9% lived with one biological parent and a significant other, and 8% lived with others (e.g., grandparents, foster parents, etc.). Of the 121 families that received treatment services, the average age for the mothers was 31 years of age and 33 years of age for the fathers. The average educational level for both parents was 8th grade.

The length of treatment (from the date the case was assigned to the mental health counselor to the date the case was closed) ranged from 1 to 33 weeks, with a mean of 11 weeks. There were a total of 991 appointments made of which 627 or 64% resulted in sessions; 184 or 18% resulted in cancellations and 180 or 18% resulted in no shows. Of the total 627 sessions held, the number of sessions per case ranged from 0-32 sessions with a mean of 5 sessions per case.

Of the 199 referrals received by the mental health component, the original presenting problem (before the assessment of the case) showed the following breakdown: In 150 cases (75%) of the original presenting problems before assessment were on the child, and in 49 cases (25%), the original presenting problems before assessment was on the parents/family. After the assessment by the counselor, only 26 (16%) of the presenting problems after assessment remained on the child; but in 134 (84%) of the cases, the presenting problem after assessment shifted to the parents/family. 39 cases did not reach the stage of assessment (Table 6).

Table 6

Presenting Problem Before and After Assessment

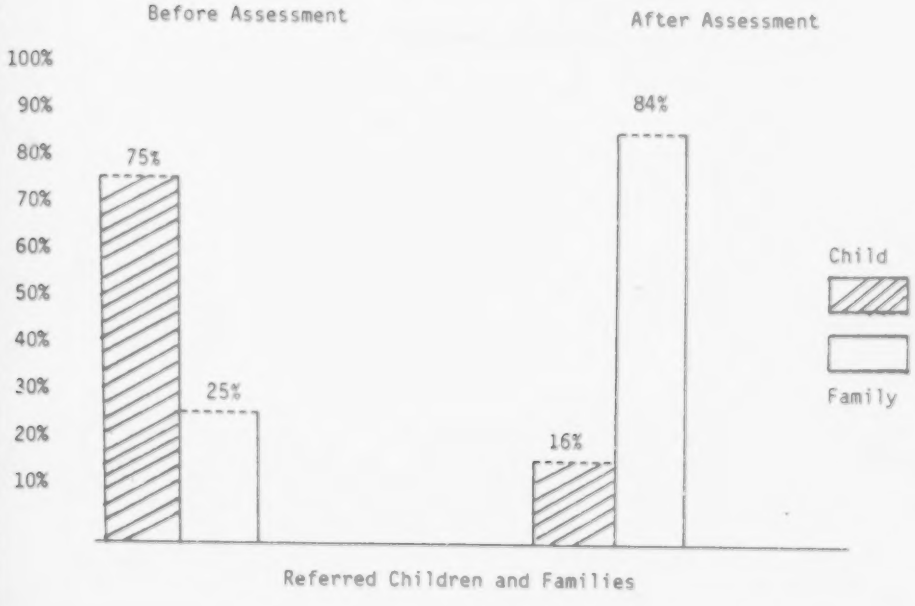


Table 7 shows the distribution of original presenting problems for both the child and the family and how they were redistributed after assessment. Most of the original presenting problems were on the child, especially in the area of aggressive behavior, speech, and inappropriate developmental behavior. After assessment there was a dramatic shift to family centered problems of which the most common problems were lack of parenting skills, individual unresolved issues, systemic dysfunctional communication, separation, divorce, and marital problems.

Table 7
Comparison of Original Presenting Problem and Problem After Assessment

BEFORE ASSESSMENT	original presenting problem	AFTER ASSESSMENT: CHILD: separation anxiety	aggressive behavior	withdrawn behavior	non-responsive behavior	short attention span	depression	speech	developmental delay	age inappropriate behavior	other	FAMILY: marital problems	separation/divorce	lack of parenting skills	death	systemic dysfunctional communication	domestic violence	drugs	child abuse/physical	child abuse/sexual	individual unresolved issues	alcohol	other	N/A
CHILD: separation anxiety	15	...	.									.					.							1
CHILD: aggressive behavior	32											..	..	.....	.	..			.				.	8
CHILD: withdrawn behavior	13											.	..	..		..			.		... ...			.
CHILD: non-responsive behavior	13																				... ...			2
CHILD: short attention span	5					.							.				.		.					1
CHILD: depression	1						.																	.
CHILD: speech	23			.				...	...			.		...		..		.			.	.		4
CHILD: developmental delay	13							...	...					.		....					.			1
CHILD: age inappropriate behavior	22								.			...		.....				.			... ...			8
CHILD: other	14										..	.		.		...					.			4
FAMILY: marital problems	5											...											.	.
FAMILY: separation/divorce	7												...								.			.
FAMILY: lack of parenting skills	6													.....							.			.
FAMILY: death	5														...									.
FAMILY: systemic dysfunctional communication	3													.		..								.
FAMILY: domestic violence	3																.	.						2
FAMILY: drugs	3													.		.								.
FAMILY: child abuse/physical	2																		.	.				.
FAMILY: child abuse/sexual	5						.													.	.		.	1
FAMILY: individual unresolved issues	5																				... ...			1
FAMILY: other	4																							4
Totals	199	3	1	1	0	1	2	5	9	0	4	11	13	37	6	18	3	3	4	2	33	1	3	39

Four types of therapy were provided adding to a total of 627 sessions. Of these sessions 161 (26%) were family therapy; 295 (47%) individual therapy; 102 (16%) conjoint therapy; and 69 (11%) play therapy.

Table 8 gives the breakdown of what occurred to mental health referrals. 19 children (9%) dropped from the school program before the referrals were received. 121 children/families (61%) received treatment. In 11 cases (5%) the presenting problem resolved itself before the initial contact.

In 41 (21%) of the cases parents either resisted or refused treatment because they denied the problem existed, had negative attitudes toward mental health, or, the refusal of one parent to participate in treatment usually discouraged the other parent and family members from coming to therapy. In 19 (9%) of the cases, children left the program before the referral was received. In 11 (5%) of the cases the presenting problem was resolved before the initial contact with mental health, while in 7 (4%) of the cases, the referral was inappropriate.

Table 8

Referred Status of Head Start Families
Identified for Treatment
N = 199

Status of Referral	Numbers of Families Referred	
	#	%
Children dropped from school program before referral received	19	9%
Children/Families received treatment	121	61%
Presenting problem resolved before initial contact	11	5%
Parents refused/resistant to treatment	41	21%
Inappropriate referral (e.g., should have been referred to another component)	7	4%
Total	199	100%

The final review on all 199 referrals (see Table 9) received by the mental health component showed the following:

(1) Parents: In 121 cases (61%) parents reported that treatment was successful, 24 (12%) said treatment was not successful and in 52 cases (27%), the final review was not applicable.

(2) Teachers: In 115 cases (58%) teachers said that treatment was successful, in 22 cases (11%) treatment was not successful, and in 62 cases (31%) the final review was not applicable; and

(3) Counselors: In 118 cases (59%) the counselors reported that the treatment was successful, in 19 cases (10%) treatment was not successful, and in 62 cases (31%) the final review was not applicable.

The final review on the 121 cases that underwent treatment showed the following:

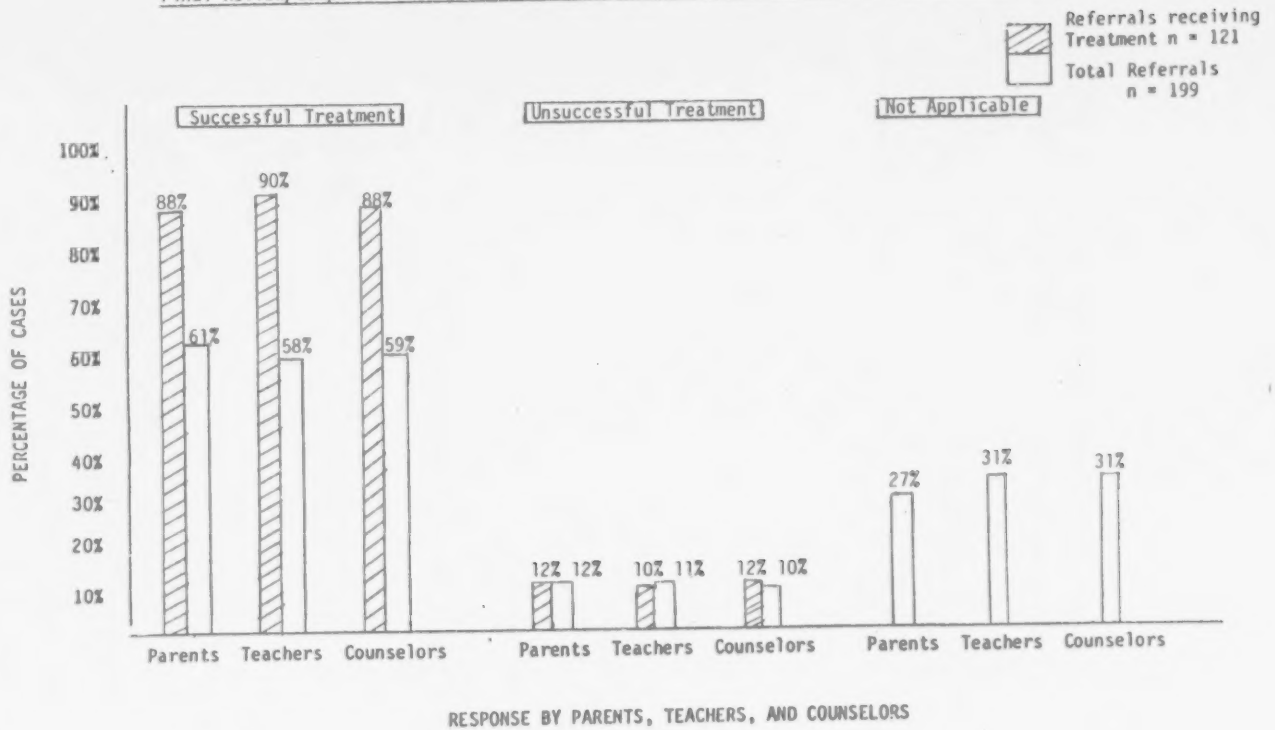
(1) Parents: In 107 cases (88%), parents reported that treatment was successful, and 14 (12%), reported treatment was not successful;

(2) Teachers: In 109 cases (90%), teachers reported that treatment was successful, and 12 (10%), treatment was not successful; and

(3) Counselors: In 107 cases (88%) counselors reported that treatment was successful and in 14 (12%), treatment was not successful.

Table 9

Final Review/Comparison of Treatment based on Parents, Teachers, Counselors Evaluations



DISCUSSION AND RECOMMENDATIONS

Staff Training and Consultation

Mental Health Classroom Observation/Supervision Cycle.

The Los Angeles Head Start Grantee recommends one hour of classroom observation per site followed by one hour of consultation. Through the Mental Health Classroom Observation/Supervision Cycle, the MHP/IP provided an average of 3½ hours of observation per class in all 64 classrooms followed by a 2 hour feedback with the teachers. Therefore, 5½ hours of consultation per class were provided adding to a total of 352 hours. If LACA were to follow the recommended hours for observation and consultation, (2 hours per site in 23 sites), a total of 46 hours of observation and consultation would have been provided. Furthermore, these 352 hours represent only one aspect of the staff training and consultation of the MHP/IP. Additional hours, as well as strategies for consultation and training of the teaching staff, were also provided adding to a total of 1,156 hours.

It was also evident teachers needed additional training in the area of social interaction so that they (as a teaching team) would function more effectively through the development of communication skills and increased classroom coordination. It is assumed that the interactions between the parents, teachers and assistants themselves would provide an effective role model for the children in regards to communication. In response to parent/teacher interaction, there is a need for initial detailed orientation of the parents on the importance and benefits of their participation in the classroom. A definite need exists for further training of teachers on the effective use of parent volunteers in the classroom.

The next highest area of difficulty was in relation to the level of positive stimulation provided to the children. 22% of the teaching staff were observed to have had problems in this area which included providing exciting and challenging activities for the children, encouraging the children's initiative and creativity, and the teachers' display of enthusiasm for their work. The mental health staff provided an important role in demonstrating techniques to the teaching staff regarding ways to increase the level of positive stimulation by pointing out the importance of encouraging children's creativity and sense of accomplishment, both of which can greatly increase a child's self-esteem. As children play a more active role in the classroom, and take age-appropriate responsibility, their social competence increases.

The Mental Health Classroom Observation/Supervision Cycle promoted early identification and intervention of children with problems. In comparing LACA's mental health referrals to other Head Start agencies in Los Angeles County it was found that the mean number of referrals from September 1 - December 31, 1984, was 8 referrals per agency representing 2% of the total Los Angeles County Head Start population. LACA had 111 referrals for that same time period, representing 11% of their population.

Is it that only 2% of the children in Los Angeles County Head Start are in need of mental health services, or, is it that children who are in dire need of mental health services are not getting referred because of little understanding and low priority for mental health services? The authors believe the latter is true and their belief is confirmed by the literature which shows 10-25% of the children in Head Start classrooms are thought to suffer from serious psychiatric and developmental disturbances. The significant difference is due to the fact the MHP/IP encouraged the early identification of children and families by conducting comprehensive classroom observations, training the teachers on identifying emotional problems and referring children to appropriate components.

Teacher Feedback for the Mental Health Classroom Observation/Supervision Cycle

Following the Mental Health Classroom Observation/Supervision Cycle, the teaching staff filled out the Teacher Feedback form on which they gave their comments on the cycle. 89% found the cycle to be helpful, while 11% found it not to be helpful.

According to teachers' responses, the vast majority were in favor of receiving training and valued the mental health staff's assistance, a fact observed throughout the program. In this study it was observed hands-on training is an effective means of improving teaching skills. When training is presented from a positive standpoint and builds upon strengths, not deficits, then the teachers are responsive. Based upon these findings, it is important to acknowledge teachers skills and expertise and to actually show them how these skills are essential in promoting an emotionally supportive environment in the classroom.

Mental Health Individual Child Observation/Action Plan

When a referral was received, a mental health counselor conducted a classroom observation of the child and worked with the teachers to develop an appropriate course of action for resolving the problems. By observing the referred child, emotional and behavioral strategies were implemented to meet the needs of the particular case. By working with the mental health counselor, the teacher had the opportunity to increase skills and develop his or her sense of competence as a teacher. Early identification and intervention took place with the potential to reduce existing problems that could have long-range damaging effects.

One of the most important aspects of this intervention was the provision of direct training to the teaching staff in handling the specific emotional and behavioral problems of a referred child. Possible causes and effects of manifested behaviors were explained and strategies for resolving these problems were given. In addition, the teaching staff acquired knowledge on the differences between the cause and the effect of behaviors and were able to recognize the need for treating the cause and not just the symptom. It is usually the symptom of a problem which is manifested in the classroom. As a result, the teaching staff was able to understand and support the approach of working with the entire family, not just the child in isolation.

The counselor made the teacher aware of the need for consistency between interventions at home and at school. The more involved the teacher felt in the team approach, the more effective he or she was in providing an emotionally supportive environment in the classroom.

It has been the authors' observation that when direct training is provided to teachers which acknowledges their strengths, then the motivational level and trust in themselves as teachers will increase.

Staff Evaluation of Mental Health Services

The mental health component was evaluated by the teaching staff. This evaluation consisted of narrative responses and covered the following areas: 1) helpful services; 2) services most valued; 3) inappropriate services; and 4) lacking or insufficient services. The results for the mental health component covered the areas of service delivery to teachers, parents and children. The purpose of these evaluations was to expose weaknesses and strengths of the component so as to provide optimal services to our children and families. These evaluations underscored the teachers importance in the Head Start program and demonstrated to them that recommendations were critical for improving the effectiveness of mental health service delivery.

Overall, the teaching staff felt that service delivery for children and families was effective. They stated on site direct training provided insight and strategies on how to minimize the incidences of behavioral problems, it facilitated their interactions with parents and gave them an understanding of the importance of identifying and treating children and family's mental health needs.

Recommendations for Staff Training and Consultation

One recommendation for a successful staff training and consultation aspect of a Head Start program is the initial orientation (or possibly re-orientation) of the staff to the primary goal of Head Start - the promotion of social competence for the children and families served by the program. Research indicates there has been a misconception that the goal of Head Start is to promote cognitive development alone in children. When conflicting opinions exist regarding the goal of a program (cognitive development vs. social competence), problems may arise in various aspects of programming leading to ineffective service delivery. On the other hand, when the staff understands the goal of the program, they can unite as a team, provide comprehensive multi-disciplinary services to promote child and family development in the fullest sense; and thus recognize the importance of mental health service delivery. When the stigmas attached to mental health are directly addressed, the process of shifting the existing negative focus on mental health to a positive understanding of the need for mental health services begins. When this is followed by giving the staff a direct, positive experience of mental health service delivery, then their receptivity will be instrumental in the coordination and implementation of the comprehensive services provided.

The literature concurs with our findings which show there is a higher rate of success in response to training when there is a high level of interaction with the trainer. One way to foster a higher level of interaction between the teaching staff and trainer is to actively involve the staff in the process of determining the areas of training. Once the teaching staff and the trainer jointly agree on a plan for training and participation, success is more likely to occur.

The teaching staff also need to have an understanding of the importance of an emotionally supportive environment. When these skills are not present, the result is most likely to be an increase in the severity of a problem which could lead to long term pathology.

The authors' recommendation is for the National Head Start Bureau to recognize the importance of staff training and consultation in the area of mental health. Since Head Start serves a high risk population faced with severe problems, there is a critical need of having qualified, trained staff in the classroom who can understand, support and promote child and family development in the fullest sense, allowing for the accomplishment of the primary goal of Head Start - the promotion of social competence.

Parent Education and Involvement

The MHP/IP sought to increase parent education and involvement through a series of activities which would emphasize parenting skills, child development, and the understanding of normal child growth and development. Overall, it was felt these activities would further develop the social competence of parents, and thus remain in keeping with the overall objectives of the study. A comprehensive, low-cost parent education and involvement program was designed by the MHP/IP which had emphasized intensive parent education. It was unique because it viewed and shifted the focus from being solely parent involvement to parent education and involvement. Though the MHP/IP under the Mental Health component made this initial plan for parent education with the approval and support of LACA's administration, when it came down to carrying out the actual program the Parent Involvement component solely designed and implemented their own plan for parent education which tended to revert back focusing more on involvement rather than education and involvement.

Along the way, plans for carrying out activities with parents seemed to have lost importance, so much so, that parent education and involvement resembled a mere supplemental activity. On another level, this problem seemed to be rooted to overall lack of clarity regarding what parent involvement, parent education, and parent participation actually mean on a policy level.

Recommendations for Parent Education and Involvement

The authors recommend the Head Start Bureau shift the current focus from parent involvement to parent education and involvement. Within the Parent Involvement Performance Standards, there is an existing focus on education. This has been a theoretical focus and to date has not been widely integrated in individual Head Start programs. It is recommended the Head Start Bureau select effective parent education models which can be implemented at the local

level based on individual needs and/or cultural relevance. These models should emphasize the role of parents as the primary educators of their children. This can be carried out by promoting parents as partners with program staff in accomplishing the goal of Head Start, and in addition, help prepare them to be trainers of other parents and thus serve as role models in the program.

Finally, these parent education models have the potential to promote the social competence of parents by enhancing their sense of self-esteem and thus creating leadership abilities which can, in turn, enhance their role as individuals, as parents, and as members of society.

In-House Mental Health Treatment Services

One of the reasons which led the authors to design and implement the MHP/IP was the clear evidence in Head Start of the need for comprehensive mental health service delivery. This need was verified not only through the authors' experience in the field of mental health and Head Start, but also through the literature. "Although Head Start programs are required to include a mental health component, no studies were located that evaluate the effect of mental health services (Synthesis Project, 1985:16)." Furthermore, the literature has consistently shown that 10% to 25% of Head Start children are in dire need of mental health services (Cohen et. al., 1979). Dr. Cynthia Barnes is the Executive Director of the Manhattan Children's Psychiatric Center (MCPC) which serves as the state children's psychiatric hospital for the borough of Manhattan in New York City. MCPC serves children and youth between the ages of 6-18 who have severe emotional and behavioral problems which require in-patient hospitalization or attendance in their day treatment program. Dr. Barnes has indicated that 80% of the children at MCPC had previously attended Head Start. Nevertheless, only 10% of these individuals had been identified while enrolled in Head Start. The remaining 90% were not identified, in most cases, until they reached the second grade and were generally incorrectly referred for speech and language problems, not the severe psychological problems they were having. For the most part, these problems were present when these children were enrolled in Head Start, yet without early identification and intervention the problems became so severe that in-patient hospitalization was required. Is it that there have been no evaluation studies to assess the impact of mental health services on children, or is it there have been no comprehensive mental health services in Head Start to be evaluated? One way to confront the high percentage of children and families needing mental health services was to design a comprehensive program that could fill the gap left by Head Start policy.

During the 1984-85 school year, 199 children and families, representing 21% of LACA's population, were referred for mental health services. 72% of these referrals were made by teachers; this high percentage was due to their daily contact with children and families. 20% of the referrals were made by parents which seems to reflect that mental health orientations for parents was effective. The remaining 8% of the referrals were made by support staff.

Of the total number of referrals received by the component, 150 (75%) had the original presenting problem identified on the child and 49 (25%) had

the original presenting problem on the parents/family. The original presenting problem refers to the reason for which the referral was initiated. It should be kept in mind that only the principal problem was calculated for purposes of these statistics. In many families, there were several presenting problems, per case. The teaching staff usually made the referral because an emotional and/or behavioral problem was exhibited by the child in the classroom. The predominant original presenting problems on the child were aggressive behavior, speech problems, inappropriate developmental behavior and separation anxiety. These findings are consistent with O'Regan, Reinherz, and Haworth (1980) who state the prevalent problem of preschool children is hostility and aggression. The predominant original presenting problems on the families were divorce and/or separation problems, lack of parenting skills, death, individual unresolved issues, sexual abuse, and marital problems. After the classroom observation, the parent/teacher conference, the preliminary and the screening sessions, the counselor was able to comprehensively assess the case and determine the cause of the problem.

After assessment of the cases, there was a dramatic shift from child-centered problems to family-centered ones. Parent/family problems constituted 84% of the problems after assessment as opposed to the 25% prior to assessment. Now, 16% of the problems were on the child, whereas before assessment, 75% of the problems were on the child (see table 6). 39 cases did not reach assessment. The initial assessments made on the child addressed problems evident in the classroom. However, when mental health counselors reassessed the child and the original presenting problem; it was discovered in most cases, that parent/family problems were the origin of the behaviors manifested in the classroom by the child (see table 7).

For example, in 31 out of the 32 referrals for aggressive behavior, the counselors discovered that after assessment, the aggressive behavior was the result of a parent/family problem. In 10 cases, it was due to lack of parenting skills; in 5 cases, individual unresolved issues of the primary caretaker; and in 4 cases, divorce and/or separation. In most cases, the cause of the problem was due to disruptive and/or dysfunctional family dynamics, and the whole family, not the child alone, was in need of mental health services. Inappropriate developmental behavior was also one of the most frequent reasons for referral for children (22 referrals). However, in all cases after assessment, it became evident the child's difficulty was due to lack of parenting skills, individual unresolved issues, or divorce and/or separation of the parents. Individual unresolved issues consisted of parents, foster parents, and/or the primary caretaker having to resolve their own individual problems which affected the child, and in most instances, the family. If the original presenting problem had alone been treated, then the child would have become the identified patient, and the origin of the problem (i.e., parent/family problem) would not have been resolved. These original presenting problems (e.g., aggressive, withdrawn and inappropriate developmental behavior, etc.) had the potential for becoming serious psychological and developmental disturbances if prevention, early identification and intervention had not occurred. For that reason, the MHP/IP emphasized the interconnectiveness of systems impacting upon the family and concentrated on treating the cause of behaviors.

In order to measure treatment success, a final review was completed on all cases. Three different sources were used in evaluating the success of

treatment: the counselor, the teacher, and the parents. The counselor assessed whether treatment goals had been successful in resolving or reducing the problem. The teaching staff was asked to evaluate success based on the resolution of the child's problem in the classroom, while the parents were asked to evaluate the resolution of the problem within the context of the family.

There are several ways in which to evaluate the success of treatment such as psychological testing before and after treatment, changes in grades and academic performance, changes in behavior, and accomplishment of treatment goals. Because of the MHP/IP's orientation, it was decided success would be evaluated by determining if, in fact, treatment goals were accomplished, and if a significant change had taken place in the home and in the classroom.

The success of treatment was evaluated for two different groups. The first analysis was based on the total number of referrals received by the mental health component (199). The second analysis was completed on the 121 cases that actually received treatment services (preliminary and beyond). A comparison was made showing the significantly higher success rate for those families who received treatment.

Based on the sample of 199 cases, among the counselors, teachers, and parents there was a consistent assessment of success rates. Counselors reported 59%, teachers 58%, and parents, a 61% success rate. Lack of success was reported on 10% of the families by counselors, 11% by teachers, and 12% by parents. The remaining cases were not able to be evaluated because the child had dropped the program, the presenting problem was resolved before time of initial contact, or it was an inappropriate referral. These figures, averaging about a 60% success rate, were relatively high, especially in light of the high risk population which was served and the severity of family and child problems that existed. This high success rate demonstrates the effectiveness of mental health treatment services (see table 8).

It should also be noted that the relationship between who the child lived with, and whether treatment was successful was not significant. Whether the child lived with both biological parents, one biological parent and a significant other, or a single parent mother, there was the same possibility of success in treatment. And while single parent families may appear to have stress and therefore greater potential for high risk, the MHP/IP found that regardless of family composition these groups can, through treatment services, resolve their problems.

There were a number of factors contributing to the high success rate of treatment services. Very important was the fact the MHP/IP provided direct, comprehensive, in-house mental health services. Because of the MHP/IP's parent orientation held at the beginning of the year and the fact the family's inherent strengths were stressed, the therapy presented a safe and supportive atmosphere for exploring mental health issues. The MHP/IP addressed the stigmas connected to mental health and how these stigmas had, in many instances, caused the community not to take advantage of mental health services. In addition, LACA's Head Start classrooms provided an entry point

for assistance to high risk families. As parents became involved in the program, they were likely to gain confidence in the teachers, the organization and themselves. They learned about the available support services, health, social services, handicap, parent involvement, and mental health and how these services could benefit the entire family along with the enrolled Head Start child. They now had access to, and it appears they developed trust in a community provider of mental health services.

There has been a longstanding view in Head Start that children and families in need of mental health treatment services should be referred to outside community mental health agencies. However, research has shown this low income population rarely uses available community mental health services for reasons which include the stigmas attached to mental health, the belief the family should be able to manage their own affairs, the distrust of bureaucracy and, for the increasing number of ethnic minorities, the lack of bilingual and culturally sensitive counselors. Finally, over the last several years, there have been severe cuts in funding for mental health services. Most of the existing funds in mental health are used for adults, in-patient mental health hospitalization, and after-care facilities. The lowest priority in mental health funding has consistently been for children, families, ethnic groups and prevention.

Another aspect of these comprehensive mental health services was the team approach. The counselor and parents reached a plan for treatment services, thus allowing the parents to feel like an integral part of the treatment process. The counselor coordinated services between the teacher and parents so a consistency in nurturing an emotionally supportive environment in the school and home existed. Parents consistently felt that treatment increased their sense of self-esteem, developed their communication skills, and assisted them in resolving personal, marital and familial problems, thus promoting their social competence. The MHP/IP's effect on the lives of these children and families may be the first step in the realization of change that can occur when a number of services are accepted and fully utilized.

The counseling staff contributed greatly to the success of treatment. Counselors were bilingual and had a knowledge of, and experience with, the different ethnic minorities which comprised LACA's high risk population. The counseling staff had extensive experience with preschool children and families, either were completing or had completed graduate school in psychology or related fields and were working on hours for their clinical licensing exam. Even though each counselor had a high case load (average 40 cases per counselor), there was sufficient time to effectively follow-through on each case. The counseling staff were highly committed and encouraged their clients to attend therapy and worked evenings so families would have every chance to attend therapy. For the most part, there was very little waiting time before the parents were seen for therapy. On the other hand, at many local community counseling agencies there is a one-three month waiting list. There was a deep sense of family, love and commitment in the population served by LACA that was reflected in the results in therapy. The MHP/IP offered a unique situation because it not only identified children and families in need of mental health services but also offered in-house

treatment. It was the concern of some Head Start administrators and staff that parents might react to these services as intrusive and, as a result, refuse or resist treatment. But, in fact, this was not the case, and the high success rate demonstrated the effectiveness of the MHP/IP's approach.

There is a need to shift the orientation of early intervention programs, in particular Head Start, which have historically focused on the child alone to an orientation emphasizing service to the entire family (see HHS, 1980). The authors believe the child should not be seen in isolation but instead viewed as an integral part of the family structure whereby problems which affect the functioning of the family, affect the functioning of the child.

This shift from a child-centered approach to a family-centered approach was borne out by the findings where the original presenting problem, in 75% of the cases, reflected child problems and 25% of the cases were parent/family problems. After assessment, however, 16% of the cases, the problem remained child-centered and the remaining 84% reflected parent/family problems.

Through this assessment, the mental health counseling staff came to realize, problems of aggressive behavior in Head Start children, for example, originated with parent/family problems such as, lack of parenting skills, separation, and marital problems. Basically, the cause of a problem was due to disruptive and/or dysfunctional family dynamics, not the child alone. It became obvious to the authors that treatment of the original presenting problems alone would have caused the child to become the identified patient and the origin of the problem would have gone unresolved. The use of an ecological model for treatment by the MHP/IP sought to bridge the gap between mental health treatment services and the interconnectiveness of systems that affect the family.

Human service delivery programs exemplify one example of this conflict. Historically these programs have viewed the individual in isolation from external issues which may impact on their lives. Attitudes emanating from human service bureaucracies have largely "blamed the victim" for their problems instead of seeing the interconnectiveness of systems which affect the family. The net effect of such views have generated the distrust and suspicion of clients towards human service delivery programs.

The ecological model addresses the origin of the problem and the interconnectiveness between the systems affecting the family, and places great emphasis on individual responsibility as a viable alternative to the position of blaming the victim. By addressing the causes of a problem, the ecological perspective allows for the improvement of the individual by promoting their social competence and enabling them to better adjust and cope with their lives.

Most importantly, through the ecological model, the MHP/IP designed a demonstration model to promote social competence in children and families. Inherent in this model was a shift from deficit models that place

responsibility for problems on families alone, to a program structure emphasizing the existing strengths inherent within the child and family, regardless of language skills, economic or educational status. The counseling staff, by viewing parental relationships as the most critical in a child's life, acknowledged and gave the utmost respect to parents in their role as the primary educators of their children. This orientation proved its success by the results in therapy.

The MHP/IP's ecological approach, has the potential to enhance Head Start as a successful early intervention, family-centered program, allowing Head Start to reach its primary goal for both the child and the family--the promotion of social competence.

Recommendations For Mental Health Treatment Services

National Head Start Bureau. A primary recommendation of the MHP/IP is for the Head Start Bureau to recognize the importance of mental health as a critical component in accomplishing the primary goal of Head Start - the promotion of social competence. This can be accomplished by recognizing the importance and need for comprehensive mental health services to the Head Start population, as well as establishing mental health as a priority in the areas of funding and training. This needs to be an all-out united effort to insure a national change in Head Start mental health services. The MHP/IP recommends that a national mental health needs assessment be conducted in Head Start for the purpose of gathering substantial data which can be used to access the needs of Head Start children and families and the levels of mental health services that are presently being delivered. Such an assessment can be useful in formulating a national plan for upgrading Head Start mental health services as well as impacting on the formulation and implementation of Head Start policy.

The Head Start Bureau can make mental health a training priority under Training and Technical Assistance (T&TA). This training should address the following points:

1) The need to shift from the existing cognitive orientation in Head Start to the original goal of social competence;

2) The importance of mental health in the accomplishment of this goal;

3) The relevance of the shift from a child-centered program to a family-centered program;

4) The emphasis on parents as the primary educators of their children;

5) The stigmas attached to mental health and ways to counteract them;

6) The relevance of switching the focus in mental health from pathology to prevention, health and wellness;

7) The importance of prevention, early identification and intervention of child and family related dysfunctions which have the potential of producing long-range damaging effects;

8) The multi-disciplinary team approach to the delivery of services to Head Start families; and

9) Working models for implementing mental health service delivery in various settings (i.e., urban, rural, etc.).

Since this Training and Technical Assistance needs to be an all-out national effort in order to become successful, the authors are recommending training be provided to the following people: (1) Head Start Bureau Administrative staff, (2) Head Start Regional Administrative staff, (3) Grantee Administrative staff, (4) Head Start directors and component supervisors staff, and (5) Head Start teaching and component support staff. The National Head Start Bureau has begun to recognize the need for mental health but, recognition, discretionary grants, and dissemination alone will be meaningless without the full support of national policy in the areas of planning, programming and funding.

Comprehensive Mental Health Services Need to be Provided by Head Start. The authors are recommending Head Start agencies implement comprehensive, in-house, direct mental health service delivery programs which provide for prevention, early identification and intervention of problems for children and families. The MHP/IP provides such a model which can be replicated and adapted in various urban and rural settings to meet the individual needs of Head Start agencies across the nation. It is further recommended Head Start urban programs hire a full time, licensed mental health professional, whose sole responsibility is the supervision of the mental health component. Historically, a paraprofessional mental health coordinator supervises two or more components (including mental health), then contracts with a consultant who provides the services.

Depending upon the size of the agency, and its budget capabilities, additional professional and/or para-professional staff can be hired. The MHP/IP employed 6 staff: 1 licensed mental health specialist and 5 full-time counselors. Six staff for 960 children represent a ratio of 1:160. The budget was $100.00 per child for the year 1984/85.

The MHP/IP recommends that a national strategy for the utilization of graduate students be designed and implemented. Head Start can set up internship programs with volunteer or stipend graduate interns in the fields of psychology, counseling, early childhood education, social work, and other related fields. Under the supervision of licensed Mental Health Specialists, all mental health staff, including interns, can undergo comprehensive training to provide in-house, direct mental health services to the children, families, and teachers. They should have a commitment to working with a high risk population, cultural sensitivity for the ethnic minority served, and, when needed, bilingual capabilities. Head Start can set up official linkages with national psychological associations such as the American Psychological Association, the National Association of Social Workers, etc. for the utilization of these students.

Head Start can then become an established, recognized, ecologically oriented training ground for future therapists and child development experts specializing in the field of children, families, high risk populations, cross-cultural counseling, prevention, health and wellness. This ecologically oriented program has far reaching implications in the area of psychology, switching the existing focus from pathology and a deficit model, to a focus on prevention, health, wellness, social competence, and family strengths.

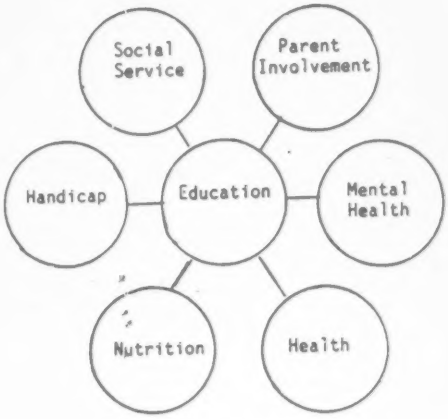
In a rural setting, different Head Start centers could pool their resources for mental health services, and jointly hire a licensed mental health specialist who could recruit, provide a plan for training and supervise a staff of para-professionals and stipend graduate interns. The great distance between many rural Head Start centers would also have to be taken into consideration in working out a plan.

If certain Head Start agencies decided not to develop a plan to provide in-house direct mental health services, then these agencies should establish formal linkages with existing mental health community agencies which would provide for the early identification and intervention in problems affecting the Head Start child and family. The mental health community agencies should have staff who are able to handle the problems associated with high risk. The authors' have observed mental health agencies generally do not provide for prevention, early identification, and intervention of problems in children and families due to large case loads, long waiting lists, and low priority in funding for services for children, families, minorities and non English speaking populations. Therefore, if these linkages are to occur, the provision of comprehensive mental health services to the Head Start population should be incorporated in the overall planning of services of existing mental health agencies. It is recommended that under the Mental Health Block Grants to states, Head Start be incorporated into the regular budget for funding.

Head Start presently serves approximately 400,000 children a year. Each family has an average of 5 people per household. Head Start has the potential to provide services to approximately 2 million people annually. A model such as the MHP/IP, which provides comprehensive mental health services in the areas of prevention, early identification and intervention, has the potential, over a generation, to affect change with 40 million people. At present, there is no other model that has the potential to strengthen the lives of children and families in this country in this way.

Shifting the Focus in Head Start from Promoting Cognitive Development to Promoting Social Competence. To date, Head Start has had its primary focus on a cognitive oriented education with an emphasis on the components serving the education component. The MHP/IP proposes a model where all the components work cooperatively and interdependently to serve the Head Start child and family. In this regard, the MHP/IP is proposing a shift from a program which has primarily emphasized cognitive development, where all the components serve the education component, to a program which focuses on the promotion of social competence. All the components including the education component, would serve the Head Start child and family.

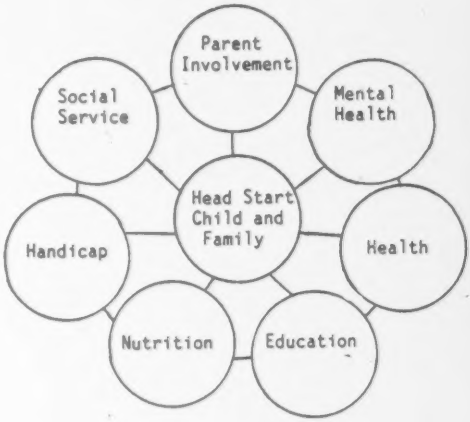
In the existing model all the service components serve the education component which primarily focuses on the cognitive development of the child (child-centered program). The MHP/IP recommends a shift to the proposed model which has all the components of Head Start, including the education component, functioning interdependently within the framework of a multidisciplinary team approach aimed at accomplishing Head Start's ultimate goal - the promotion of social competence in children and families (family-centered program) (see diagram).



EXISTING MODEL

Focusing on the cognitive development of the child

Child Centered Program



PROPOSED MODEL

Focusing on the promotion of social competence in the child and family

Family Centered Program

An Ecological Model for Mental Health Service Delivery. The MHP/IP is recommending the use of an ecological model with its broader focus over the less effective deficit models. The child is not a cognitive entity alone. He or she must be viewed from an ecological perspective. The child has a physical body, a social and emotional essence, and must be viewed as an integral being who interdependently relates to his family, community and society. The authors are recommending the Head Start child and family be viewed from a holistic systems orientation; a multi-vectored ecological approach to treatment, where the child and the family are seen as interacting within a number of systems - biological, psychological, social and environmental. The MHP/IP suggests that for educational and human service delivery on a national level, the child no longer be viewed in isolation from the family. A shift needs to occur from a

child-centered program to a family-centered one where the family is viewed as an integral unit. A problem that affects one, affects the whole.

The ecological model addressed the origin of the problem and the interconnectiveness between the systems affecting the family. Therefore, when a child is exhibiting problem behavior in the classroom, (e.g., aggression, withdrawal, etc.) the origin or cause of the problem, (e.g., family conflict) is treated. Many in Head Start and in human service delivery systems have tended to focus on the effect of the problem rather than the cause and thus perpetuating the belief the child and family are the "victims of society". For instance, when a child's basic needs are not met, (i.e., food and shelter), Head Start programs tend to give the child a "head start" in the classroom and help to resolve the basic need for food and shelter instead of looking at the causes which led the family to be dysfunctional. Poverty, discrimination, unemployment and other social ills of the times seriously impact on the healthy functioning of a family. However, the fact some families are faced with these problems and are still able to successfully function, leads one to believe that factors other than environmental and social ones also contribute to family functioning. The potential to overcome social ills begins when one becomes aware of the interconnectedness between the internal (persona) and external (societal) factors, then one can begin to create attitudinal change which can then lead to transformation on individual and societal levels.

The MHP/IP promotes individual responsibility, and proposes alternatives for problem resolution instead of blaming the victim and/or blaming society. In order to impact on the total family system, an emphasis should be placed on treating the entire family, not just the child in isolation who has become the identified patient. The child's behavior is seen as one of the effects of a family's dynamics. Human service delivery systems need to treat the cause of a problem, not just the effect, if our goal is to make long term significant changes in children and families. The families were assisted in looking at both internal and external issues not in terms of deficits, but rather as areas that could be changed if the individual so desired. The MHP/IP is recommending the ecological approach become the state of the art in programs aimed at strengthening families abilities to improve their lives and successfully function in society.

Implementation of a Team Approach to Mental Health Service Delivery. A mental health service delivery plan needs to emphasize a team approach where the parent, teacher, and mental health counselor work together in promoting child and family development in the fullest sense. When there is coordination between parents, teachers, and counselors, a consistency will result between the home and school environment. Teachers need to be trained to recognize the criticalness of the parents' role and how to effectively interact with parents. Parents are viewed as the primary educators of their children and play a critical role with counseling staff in jointly deciding the course of treatment.

Impacting Change in Human Services and the Educational System. The MHP/IP can serve as a model to affect change in human services, and the educational system. It proposes that programs in human services move away

from an orientation on the deficit model, to a focus on a competency model building on the child and family's inherent strengths. Programs need to switch their concentration from pathology and treatment to a focus on prevention, health and wellness. For human services and the educational system the child can no longer be viewed in isolation from his or her family. Families need to be treated as an integral unit.

Much of the work done through the MHP/IP, involved primary and secondary prevention. This preventive focus contrasts with the typical tertiary remediation interventions which traditional mental health programs focus on. Many of the problems seen at LACA were at early stages of development. Early intervention had the potential to resolve these problems. As an example, in many cases, the potential for child abuse was present. However, because of the early intervention which focused on parenting skills, reducing stress and improving family communication, these potential problems were diverted. If some of the money for the treatment of child abuse were redirected to the prevention of this problem through such programs as the MHP/IP, it is assumed there would be a substantial reduction in severe problems such as child abuse.

For the educational system it is recommended all children be observed during the first two years of elementary school by a mental health specialist so prevention and early identification of psychological and developmental disturbances could occur. If a problem were observed, a conference would be scheduled with the parent, teacher and mental health specialist. At this time a plan for intervention would be recommended. Either the child and family could be seen by the school psychologist or graduate psychology/counseling interns, or a referral to an outside agency could be made. During the first two years of school, all parents would be given the opportunity to attend parent education classes. The focus would be on viewing parents as the primary educators of their children and increasing their understanding and skills in their critical parental role.

For these changes to occur in the educational system, the public must first become aware of the importance of mental health and its impact on a child's educational performance, his or her functioning within the family system and in society at large. This awareness needs to be followed by legislative action and budget allocations. Mental health programs in the educational system and programs such as the MHP/IP, in conjunction with longitudinal studies, could be an important step in reducing mental illness, juvenile delinquency, school drop-outs, incarcerations, alcohol and drug abuse. These programs have the potential for strengthening the children and families of this country. The education system is in dire need to switch its current focus from the cognitive approach to a focus on social competence. The child would be viewed as a whole person, emphasizing his or her interaction with oneself, the family, and society. The ecological orientation promotes social competence which nurtures an individual's sense of self-esteem, individual responsibility, personal integrity, interdependence, and one's effectiveness in dealing with his or her environment, and a concern for the whole.

Cost Effectiveness

In projecting cost-effectiveness for the MHP/IP it was assumed that early intervention through the provision of mental health services were similar to those secured through early education - the children would become socially competent and able to achieve within the regular educational system as they enter and progress through public school. Several studies can be cited which address the issue of cost-effectiveness for early intervention. Wood (1980) reviewed the cost of providing special education intervention at various age levels. The data collected demonstrated that the cost per child to age 18 decreases as the age of intervention decreases (e.g., intervention at age two = $37,600; intervention at age six = $56,816, intervention at age six with no eventual movement to regular education = $53,340). Thus, assuming a $2,304 cost each year in which a student is not involved in an intervention program between the ages of two and six, the cost of education per child to age 18 receiving intervention at age three, would be $39,904. This is a savings of $6,912 per child if contrasted to intervention at age six. Additionally, assuming early intervention leads to placement within the regular education setting, the average per child savings would be $13,436. Other evidences for cost effectiveness of early intervention programs can be found in the literature (Weber, 1978). Further, a cost benefit analysis would give additional consideration to savings which resulted from taxes recovered from earnings, income maintenance reductions, and institutional avoidance (special schools, penal, as well as mental health institutions). For example, mental health institutionalizations average $50,000 per year. The budget for the MHP/IP was $125,000. $96,000 of this amount covered direct mental health services for 960 children. Therefore, the cost was $100.00 per child per year. Head Start presently serves approximately 400,000 children. If mental health services were provided at a cost of $100.00 per child, per year it would cost $40 million per year. Head Start's present budget is $1 billion per year and the $40 million per year that is being proposed to be used for mental health represents 4% of the total budget.

Social Competence and the Ecological Approach to the Head Start Family

Throughout this analysis, the ecological approach to the understanding and assessment of children and families has been emphasized. It is critical that the reader understand the process of analysis and the implementation of this approach. For example, it is important that intervention strategies and evaluation methods be merged into this ecological approach. The way a problem is assessed will determine how a problem becomes defined. The levels of assessment may be determined from the individual, group, organizational, concern, then strategies of intervention will be directed at group or systems change.

Although Head Start is based, in theory, on this paradigm, the focus throughout the program's development has been directed primarily at the individual child level. That is, the primary focus has been directed at the improvement of cognitive abililities rather than the observed competence of the child in the classroom. Cognitive abilities of the child had, until this effort, largely become the determining factor of competence. Families have

been an integral part of the Head Start philosophy, however, the emphasis of components, such as Parent Involvement and Social Service, have attempted to respond on a broader systems level to this orientation.

Traditionally, however, the components have worked with parents alone in this service delivery. The MHP/IP is now recommending that all Head Start components reorient their delivery system to serve Head Start children, siblings and parents as an integral family unit. Specifically, whether a particular component works primarily with the child (Health and Education), the parents (Parent Involvement and Social Service), or with the family (Mental Health); it is time to shift attitudes where the components are aware of and serve children and parents as a family unit.

From assessment to treatment intervention to outcome evaluation, the ecological dimensions which address biological, psychological, social and environmental factors, influence the potential for growth and prevention of long-range problems. All of these factors have their effect on the abilities of any child and family for a healthy and productive life.

The concept of social competence presented in this study is directly linked to the concept of mental health prevention and intervention. The promotion of positive mental health concepts and the prevention of problems through early identification indicate, as a result of the findings in this project, that social intervention with young children and families is a strategy whose time has come.

The promotion of mental health is critical in accomplishing the primary goal of Head Start, the promotion of social competence for children and families. The full support of national policy in the areas of planning, programming and funding for mental health in Head Start with an emphasis on prevention, early identification and intervention is vital. More action is needed if mental health services are to become integrated into Head Start programs at national and local levels. The time has come to actively prevent long-term damaging psychological and developmental disturbances through early identification and intervention. Only through a commitment to positive mental health services can the social competence and well-being of Head Start children and families be ensured.

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TRI-COUNTY COMMUNITY COUNCIL, INC.
301 North Oklahoma Street
Bonifay, Florida 32425

Tri-County Community Council, Inc. uses the Community Services Block Grant to assist low-income participants, including the elderly, preserve their food by using canning centers where they receive technical assistance. This activity results in the clients eating more nutritiously and saving on their food and energy costs. Training and garden supplies are provided to low-income families so they can grow their own food. Emergency assistance grants are provided to those who are homeless and have no other resource to turn to for assistance when they need food and/or utilities. Another service we offer is transportation for clients to pick up their U.S.D.A., go to canning centers and go to community meetings.

Community Services Block Grant funds are essential in providing the services described; however, CSBG funds indirectly benefit many economically disadvantaged. Community Action Agencies have been fortunate in using a portion of CSBG funds as Secondary Administrative Expense. This SAE helps support, administratively, other programs; allowing funding to be used primarily for service.

One such program is Head Start. The close working partnership of CAA's and Head Start programs is renowned. Their excellent partnership has been enhanced through the use of CAA and CSBG funds in administering Head Start programs.

Community Services Block Grant funds make it possible for Head Start funds to be used to provide service to the four-year old children and their families. However, the partnership found by CAA and H.S. allows the Head Start parents to benefit from the other programs administered by the Agency. Services made available to the H.S. parents include access to the U.S.D.A. commodity distribution program, use of canning centers, rental assistance through the HUD Section 8 Rental program and referrals to the Job Training Partnership Act - Title II-A program for On-the-Job training and/or Classroom Training.

Tri-County Community Council, Inc. is the coordinated transportation provider and we transport the children daily to school and back home. However, transportation is available to the H.S. family members, if they are eligible for Medicaid, WIN, JTPA, etc.

Another support made more available because of the CAA/H.S. partnership is the use of Retired Senior Volunteer Program volunteers. Tri-County Community Council, Inc. administers the RSVP and the Head Start director utilizes the RSVP volunteers for In-Kind and volunteers in the centers.

We feel that the major importance of a CAA/H.S. partnership is the availability of all the resources offered, to the Head Start program participants (children and parents), through the various Tri-County Community Council, Inc. administered programs.

djh
2/7/86

THE VITAL LINK
BETWEEN THE COMMUNITY SERVICES BLOCK GRANT,
AND HEAD START CHILD DEVELOPMENT, AND
FAMILY AND INDIVIDUAL SERVICES

The Experience of the Orange County Department of Community Affairs

Social services outreach staff, funded in part by the Community Services Block Grant, plays a major role in the recruitment of Head Start children, particularly during the summer Head Start recess. This effort is essential for locating children who most need and could most benefit from the pre-school child development program. These same workers contribute to strengthening the family unit by assisting parents to obtain needed services, including job training and employment, consumer education, parenting skills.

Head Start teaching staff also conduct home visits and outreach. However, due to their limited hours, about 6½ daily, and the nature of their skills, parent contact must focus primarily on center activities and child development progress. Counseling and assistance for other needs requires continuous training and specialized skills.

Families with children who are not yet enrolled, or no longer enrolled in Head Start, or who cannot take advantage of this opportunity due to limited capacity of the program to enroll all eligible children - are not eligible for assistance and guidance through Head Start. The CSBG program can operate in this broad area to assure that needy, qualified families benefit from community resources.

CSBG funds and staff provide a variety of important services to Head Start families, not available from Head Start funds. Examples include home gardening, distribution of surplus commodities, emergency energy assistance, summer feeding and recreation for youth, youth job counseling-training-employment, help in budgeting and understanding contracts, ect. Likewise, support is provided to Head Start program operations and administration. Examples include transportation, fiscal management, program planning and development, center maintenance and repairs, and developing appropriate training for staff and parents.

This partnership between CSBG and Head Start helps to assure a quality child development program. In addition, CSBG, with its flexibility, responsiveness, and low administrative overhead, is able to react to local situations and handle problems which other organizations are not equipped to do. Examples of this include the Refugee assistance program, emergency assistance to farmworkers affected by the freezes, and the distribution of USDA commodities. Community Action Agencies have a unique facility for outreach, assessing community needs, and garnering volunteer support and in-kind donations. Appropriately, it is through CSBG, and its parent organizations, the Community Services Administration and the Office of Economic Opportunity, that demonstration and model programs were initiated. Many of these have become established as seperate entities once their value was proven. Under CSBG, this type of planning, development, and program conduct can be accomplished with minimum start-up costs, low administrative overhead, and rapid start-up time.

Without continued existence of the Community Action Agency through CSBG funding, it can be anticipated the quality, and perhaps even existence, of Head Start will be in jeopardy, that a continuity of support for families before and after Head Start involvement will be broken, and the special capacity to reach out and motivate the poor - irregardless of age, sex, cultural affiliation, or physical condition, will be lost.

ORANGE COUNTY DEPARTMENT OF COMMUNITY AFFAIRS
FACTS AND FIGURES 1984 - 1985

The Orange County Department of Community Affairs is the local Community Action Agency for Orange and Osceola Counties. Based on needs assessments, programs are designed and carried out to assist the poor in reaching self-sufficiency and to provide necessary emergency services.

To make services more accessible to eligible clients the Department operates its program through eight (8) Community Centers and four (4) Head Start Centers.

Community Services

22,036 low income families were provided information and referral, outreach contacts in employment, housing, energy, nutrition and other job training programs.

10,811 clients were provided counseling services.

1,053 clients received follow-up review to determine if services were provided.

576 families received service in Orange, Osceola, and Seminole Counties through the Farmworker Emergency Assistance Program.

112 migrants were provided with services and follow-up, and referrals to Adult Migrant Education Program.

601 clients were referred to HRS Low Income Energy Assistance Program.

Head Start

997 children served through Head Start Options Center and Home Base; 876 children screened and 176 diagnosed as needing and completed medical treatment; and 835 children screened, 473 diagnosed and completed dental treatment.

40 children receive services through an innovative program called G.U.I.D.E. (Group Unity and Intervention Develop Esteem). These children have been or at risk of being abused or neglected. They receive special socialization twice per week for interaction with their peers in a safe and nurturing environment.

120 of the children served in Head Start were handicapped, with the following conditions: physical handicaps, mental retardation, health and speech impairments, emotionally disturbed, and learning disabilities.

90 Home Based parents received training in parenting skills, child development and nutrition education.

Housing and Safety

10 families recruited and certified for Community Development Housing Rehabilitation programs.

40 families were assisted with severe mortgage management problems.

1,437 low income and Head Start families received Energy, Safety and Fire Prevention training.

Linkage and Coordination

10 Agencies were provided space in the Community Service Centers: Community Coordinated Child Care, Legal Services, Mental Health, Food Stamps, Urban League, Health and Rehabilitative Services, Florida State Employment Services, Orange County Social Services, Apopka Improvement Association and East Orange Community Action.

12 Community Based Organizations were provided technical assistance and support services.

Nutrition

179,804 meals were provided to Head Start children, assuring two-thirds of the nutritional requirements of each. This included 71,081 breakfasts, 105,255 lunches, and 3,468 afternoon snacks.

148,067 nutritionally well balanced meals served through Summer Feeding Program at 41 service sites.

12,546 families received assistance through the USDA surplus commodity distribution of cheese and other foods on a monthly basis.

42 gardens were grown through the Self-help Gardening Project.

Resource Mobilization

3,527 volunteers donated their services in various capacities, and $1,023,097 was provided in professional services, facilities, cash and donations.

Transportation

245,609 ridership for Community Affairs Para-Transit System in West-Northwest and East Orange County.

228,595 special transportation one-way trips to service Head Start students, elderly, handicapped and other low income persons.

Youth Services

121 youths, 13-19, were provided employability skills training and career development counseling through the Youth Opportunity Unlimited Program.
26 employers were contacted;

118 jobs were developed;

72 youth successfully placed in unsubsidized jobs.

1,000 low income youths, ages 6-16 enrolled in summer recreation programs at seven area Community Service Centers.

50 youth returning to Orange County from Job Corps received job counseling, housing, employability skills/training, and budgeting assistance.

Orange County Department of Community Affairs
ADMINISTRATIVE OFFICES
22 West Lake Beauty Drive
Orlando, FL 32806
(305) 420-3131/420-3827

February 26, 1986

Senator Paula Hopkins, Chairperson
Reauthorization of Head Start Committee

I would like to voice a concern that needs expressing at this time. Region III (and other regions) is now being denied (by the administration) a Parent Involvement Specialist to coordinate and respond to parent needs in the program. Since it is through this vital leadership role that Head Start has in the past met the challenge of the poor family - by involving parents totally in the program, the plight of today's family is in more need than 20 years ago when Head Start began its crusade. I feel that the Committee can secure Head Start's ongoing success by recommending that the Parent Involvement Specialist position be immediately filled in all Regions. Doing so would enable Head Start's continued leadership in building stronger families.

Today the American family, defined by one parent as "a group of folk living, working and playing together for their survival", is under assault from all directions.

1. Economic conditions demand more adult work time, pulling parents from the home environment for longer periods.
2. Unhealthy peer pressure draws youth from the loving protection of home into the destructive areas of alcohol abuse, drugs, and immortality.
3. Most of our family aid programs are designed to keep poor folk lazy and dependent, and in a single parental state fearing to lose monetary benefits.

Head Start is one of the few programs addressing the needs of poor families at this time. Its shining record of not only educating children, but training, educating and building self esteem in parents through workshops, field trips and decision-making group encounters, speaks for itself.

II.

I have no doubt that the Senate Committee shall reauthorize Head Start due to its fine performance record.

Sincere thanks for allowing the concerned Head Start Parents of Delaware to be heard.

Winnie Cooper

Winnie Cooper
Parent Rep. Region III H.S., Inc.
Board of Directors

Vice-Chairperson, Delaware State
H.S. Parents Assn., Inc.

Chairperson, New Castle County H.S,
Inc. - Policy Council

child
CHILD INC
11th & WASHINGTON STS
WILMINGTON
DELAWARE
19801
TELEPHONE
(302) 655-3311

February 26, 1986

TO WHOM IT MAY CONCERN:

This is to express my support for the New Castle County Head Start Program and the work this program is doing for the families and young children it serves. For the past eight years, CHILD, Inc. has provided parent education courses for the Head Start Centers in New Castle County, and I have observed firsthand the effective manner in which Head Start has provided a sound educational foundation for the children as well as using various community resources to support the families that participate in this program.

The family is the primary institution in this country which supports our most important resource - our children. Early childhood education and family support services provide the foundation for these youngsters.

Programs such as Head Start are a critical component in helping our children get the "head start" they need. The Head Start must continue to this end.

Patricia P. Gercke

Patricia P. Gercke
Project Director
Parent Education Program

PPG/LLB

JOSEPH M. DELLOLIO, EXECUTIVE VICE PRESIDENT

DELAWARE CURATIVE WORKSHOP, INC. 1600 WASHINGTON STREET • WILMINGTON, DELAWARE 19802 • (302) 656 -21

February 26, 1986

TO WHOM IT MAY CONCERN:

For more than twenty years the Head Start Program has been serving the socially and economically disadvantaged children of America. As a direct result of the many programs operating across the country, hundreds of thousands of children have been given the opportunity to enter school as well prepared as their more affluent peers. Long-term research has indicated that Head Start children not only do better in school, but both they and their parents have higher expectations and aspirations for them. Parents have been encouraged to participate in the education of their preschool children -- a privilege not generally offered by the public school system, although research indicates that parents are the first and best teachers of young children.

We have spent years of time and millions of tax dollars establishing a program designed to equalize educational opportunity for children starting out in school. It would be a grave mistake to destroy that opportunity by eliminating or reducing funding for Head Start.

I wholeheartedly support the continuance of Head Start programs at their current funding level as part of our governmental responsibility to the young children of the United States.

Sincerely,

Marjorie B. van Gulick

Marjorie B. van Gulick, M.S.
Director of Special Projects

MvG/m

Senator HAWKINS. I want to thank all the witnesses today. They were all women. They are committed to the Nation's children and to the programs that serve children the best. That testimony will be valuable in evaluating the legislative needs of the Head Start Program with a proud history and a future of promise.

That concludes the hearing.

[Whereupon, at 12:12 p.m., the subcommittee was adjourned.]

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